FOURTH EDITION

THE FIRST *Interview*

JAMES MORRISON

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THE FIRST INTERVIEW

FOURTH EDITION

James Morrison

THE GUILFORD PRESS
New York London

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A Division of Guilford Publications, Inc.
72 Spring Street, New York, NY 10012
www.guilford.com

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Library of Congress Cataloging-in-Publication Data

Morrison, James R.
The first interview / James Morrison. — Fourth edition.
pages cm
Includes bibliographical references and index.
ISBN 978-1-4625-1555-4 (hardback : acid-free paper)
1. Interviewing in psychiatry. I. Title.
RC480.7.M67 2014
616.8900835—dc23

2014006717

For Chris and Eric

About the Author

James Morrison, MD, is Affiliate Professor of Psychiatry at Oregon Health and Science University in Portland. He has extensive experience in both the private and public sectors. With his acclaimed practical books—including, most recently, *Diagnosis Made Easier, Second Edition,* and *DSM-5 Made Easy: The Clinician's Guide to Diagnosis*—Dr. Morrison has guided hundreds of thousands of mental health professionals and students through the complexities of clinical evaluation and diagnosis. His website (*www.guilford.com/jm*) offers additional discussion and resources related to psychiatric diagnosis and DSM-5.

Preface

The First Interview resulted from my desire to write a manual on interviewing mental health patients that was based as much as possible on objective research and best-practice principles. Of course, that was a pretty tall order when the first edition was published over two decades ago, and it remains so today; there isn't yet nearly enough controlled research to guide interviewers through the process of evaluating mental health patients. That's why, although I've updated this new edition with every scrap of new information I've been able to collect, the text still embodies a synthesis of the best techniques I've been able to cull from both the science and art of interviewing patients.

Any published book is really the work of more than one person, and I remain grateful to all those who have helped me over the years. They remain too many to name them all. But there are several people to whom I owe a special, ongoing debt of gratitude.

Matt Blusewicz, PhD, Rebecca Dominy, LCSW, Nicholas Rosenlicht, MD, Mark Servis, MD, and Kathleen Toms, RN, all contributed to the first edition. James Boehnlein, MD, generously read and provided a critique for the third edition. Dave Kinzie, MD, provided essential information for this edition. As always, Mary Morrison provided insightful and relevant comments at various stages of the preparation of the manuscript. I'll be forever grateful to the crew at The Guilford Press, especially my long-time friend and editor, Kitty Moore, for her continuing wisdom and support. Marie Sprayberry, probably the best copy editor in the world, has immeasurably enhanced the looks and readability of this book with her close attention to detail. And Anna Brackett, *still* my editorial project manager—thanks again for your skills and forbearance in the face of too many author's requests for change.

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INTRODUCTION

What Is Interviewing?

You'll probably never forget your first interviewing experience; I know I'll forever remember mine. The patient, a young woman hospitalized with a thought disorder that turned out to be early schizophrenia, spoke vaguely and often wandered off the topic. She'd occasionally make sexual references that I, a young student in a more innocent era, had never before encountered. I wasn't sure what to talk about, and I spent more time planning what to ask next than I did considering what the previous answer meant. Despite it all, this patient seemed to like me, which was a good thing; I needed three more trips to the ward that weekend just to get the entire history.

I now realize that my early experience was about par for the course. No one had told me that most novice interviewers have trouble thinking up questions, or that many feel uncomfortable with their first few patients. I wish someone had pointed out what I now know: that mental health interviewing is usually easy and almost always quite a lot of fun.

It should be both. After all, clinical interviewing is little more than helping people talk about themselves, which most people love to do. In the field of mental health, we ask patients to reveal something of their emotions and their personal lives. Practice teaches us what to ask and how to direct the conversation toward the information we need to help the patient best. Developing this ability is important: In a survey of practicing and teaching clinicians, comprehensive interviewing was ranked the highest of 32 skills needed by mental health practitioners.

If interviewing only involved getting patients to answer questions, clinicians could assign the task to computers and spend more time drinking coffee. But computers and paper questionnaires cannot begin to perceive a nuance of wording, or assess the hesitation or the moist eye—signs that can alert a live clinician to a fruitful line of inquiry. A good interviewer

must know how to work with a range of different personalities and problems: to give free rein to the informative patient, to guide the rambling one, to encourage the silent one, and to mollify the hostile one. Nearly anyone can learn these skills. There is no single kind of interviewing personality, and you can succeed with a variety of interviewing styles. Still, you will need guidance and practice to develop a style that works well for you.

Clinical interviews are used to accomplish various goals, of course, and professionals from diverse fields have different agendas. But all interviewers—psychiatrists, psychologists, family practitioners, social workers, nurses, occupational therapists, physicians' assistants, pastoral counselors, and drug rehabilitation specialists (I apologize if I've left anyone out)—must first obtain basic information from each patient they encounter. The similarities in the sort of data they need far outweigh any differences that might be expected from their different kinds of training and perspectives.

Good interviewers share three features. They . . .

1. obtain the greatest amount of accurate information relevant to diagnosis and management,
2. in the shortest period of time,
3. consistent with creating and maintaining a good working relationship (rapport) with the patient.

Of these three components, (1) the database and (3) rapport are crucial. If you ignored time constraints, you could provide good care, although you might have difficulty coping with more than a very few patients at one time.

Your first contact with any patient could be made for a variety of reasons—a brief screening, an outpatient diagnostic intake, an emergency room visit, a hospital intake, or a consultation for medication or psychotherapy. A nurse clinician might need to develop a nursing treatment plan based on several behavioral diagnoses. Forensic reports and research interviews have very different goals, but their methods and content have much in common with all the other types of interviews I've mentioned—each of which is a specialized use of the basic, comprehensive initial interview. Whatever your interview goals, this book aims to present the information you should try to obtain for all patients and to recommend techniques that will help you during the different stages of your interview.

Over the past several decades, we have learned a great deal about the interview process. However, in my everyday evaluations of young mental health professionals, I am often disconcerted at how little this knowledge is being used in training. Clinicians often use far less than the

time allotted for an interview, fail to ask about suicidal ideas, and forget that many mental health patients also have substance use issues. In short, much of what we know about the processes of interviewing and evaluation is being ignored. *The First Interview* attempts to remedy this deficit. Addressed primarily to beginners, it emphasizes the basic material that clinicians of all mental health disciplines need to know. I hope that experienced clinicians will also find this book a helpful review.

THE NEED FOR COMPREHENSIVE INFORMATION

Clinicians can view a patient in an astonishing variety of ways. Indeed, all clinicians should be able to view each patient from biological, dynamic, social, and behavioral perspectives, because a single patient may need the treatment implied by any or even all of these theoretical standpoints. For example, the problems of a young married woman who drinks too much alcohol might be determined by a combination of factors:

> *Dynamic*. Her overbearing husband resembles her father, who also drinks.
>
> *Behavioral*. She associates drinking with relief from the tensions induced by these relationships.
>
> *Social*. Several girlfriends drink; drinking is accepted, even encouraged, in her social milieu.
>
> *Biological*. We should also consider the genetic contribution toward alcohol misuse from her father.

A comprehensive evaluation brings out the contributions of each of these points of view. Each is folded into the treatment plan.

Throughout the book I emphasize the need to hold all perspectives when you are conducting a comprehensive interview. Unless you do a complete evaluation, you are likely to miss vital data. You might not learn, for example, that a patient who seeks help for a "problem of living" actually has an underlying psychosis, is in the midst of a depression, or misuses substances. Even if your patient turns out to have no actual mental disorder, you need to understand how past experiences contribute to the current problems. Only a complete interview can satisfactorily give you this information.

Needless to say, you will obtain much more additional information as treatment progresses. You may even find that you must revise certain of the opinions you formed during your first meeting. But you can plan rationally for management only if you first carefully elicit the relevant material during the initial interview.

Your success as a mental health interviewer will hinge on several different skills. How well can you elicit the entire story? Can you probe deeply enough to obtain all the relevant information? How quickly can you teach your patient to tell you accurate, pertinent facts? How adequately do you evaluate and respond to your patient's feelings? Can you, when necessary, motivate your patient to reveal embarrassing experiences? All of these skills are needed by anyone who must elicit mental health histories. The time to learn them is early in your training, before ineffective—or even maladaptive—interviewing habits become a fixed part of your style. The benefits of early training should persist for a lifetime.

More than half a century ago, two volumes set the tone for interviewing style: *The Initial Interview in Psychiatric Practice* by Gill, Newman, and Redlich, and *The Psychiatric Interview* by Harry Stack Sullivan. Although many other books on interviewing have appeared over the years, most have followed the models established by these two volumes. But taste and needs have changed over the decades, and such venerable works no longer adequately serve the mental health interviewer. Over the past several decades, a number of research papers—most notably those by Cox and associates—have provided a scientific basis for modern interviewing practice. I have based much of this book on these sources. I have also consulted nearly every available relevant monograph and research article on interviewing published during the past 60 years. Citations for the more important of these are provided in Appendix F.

In their monograph, Cannell and Kahn (1968) stated, "The people who write instructions and books for interviewers are not themselves given much to interviewing." At least in the case of *The First Interview*, that assertion is dead wrong. A significant part of what has gone into this volume comes from my own experience over the years with more than 15,000 mental health patients. The interviewing approach I recommend is an amalgam of clinical research, the experience of others, and my own perception of what works. If it sometimes seems formulaic, it's a formula that works well. Once you have learned the basics, you can adapt and expand it to create your own interviewing style.

THE IMPORTANCE OF PRACTICE

When I was in training, my professors often said that a student's best textbook is the patient. Nowhere is this truer than in learning to do a mental health interview. Indeed, no textbook can be more than a supplement—a guide to the real learning that comes through experience. I therefore urge you to practice early and often.

First, read Chapters 1 through 5 quickly. Don't try to memorize this material; the amount may be daunting, but it is presented in sequence to

help you learn it a bit at a time. (Appendix A provides a concise outline of the information you need and strategies you can use at each stage of the typical initial interview.) Then find a patient who will help you learn.

For the beginning interviewer, patients hospitalized in a mental health unit are an excellent resource. Many of them have been interviewed before (some are highly experienced!), so they have a good idea of what you expect of them. Even on contemporary hospital wards with many scheduled activities, they usually have time available. Many patients appreciate the chance to ventilate, and most enjoy the feeling that from their own difficulties some good can come—in this case, the training of a mental health professional. (A study in 1998 found that most patients were highly satisfied with the students who participated on their hospital care teams; another study reported that students were experienced as "kind and understanding" by patients, most of whom said they'd be happy to repeat the experience.) And sometimes an interview by a fresh observer, even a trainee, reveals new insights that can help redirect therapy.

So enlist the aid of a cooperative patient and start to work. Don't worry about trying to find a "good teaching patient"; for your purposes, any cooperative patient will do, and all lives are inherently interesting. Don't try to follow an outline too closely, especially in the early going. Relax and try to give both yourself and the patient an enjoyable experience.

After an hour or so—a longer session will be too tiring for both of you—break off the interview with the promise that later you'll come back for more. Return to *The First Interview* to read about any areas of interview management that gave you trouble. Carefully compare the personal and social information you have obtained with the Chapter 8 recommendations (which are also outlined in Appendix A). How complete is your mental status exam? Compare your observations with the suggestions in Chapters 11 and 12.

A student might reasonably ask, "How can I interview about mental disorders when I know so little?" Doing a complete interview does imply knowing the symptoms, signs, and course typical of various mental disorders, but you can study these while you learn interview technique. In fact, learning about disorders from patients who have experienced them will fix the characteristics of these diagnoses in your mind forever. In Chapter 13 you will find listed the features that you should cover in your interview, broken down by the areas of clinical interest your patient presents.

Armed with a list of the questions you forgot to ask the first time through, return for another session with your patient. As I learned that weekend as a beginning medical student, there is no better way to learn what to ask than by going back to correct your own omissions. The more patients you interview, the less you will forget. When you have completed your interview, any of several standard textbooks (see Appendix F for

an annotated list) can help you with the differential diagnosis of your patient's disorder.

You will become skilled faster if you have feedback from an experienced interviewer. It could be direct, as when an instructor sits with you while you interview your patient. Numerous studies have demonstrated the effectiveness of audio or video recordings, which can be played back while you and your instructor discuss the facts you have omitted and the interview techniques you could have used to better effect. You will probably find that you can learn a lot just by listening in private to recordings of your own early interviews. I've provided a score sheet in Appendix E to help you evaluate the content and process issues of your interviews.

CHAPTER 1

Openings and Introductions

By the time you have completed an initial interview, you should have (1) obtained information from your patient and (2) established the basis for a good working relationship. The information includes various types of history (a *history* is a detailed account that includes current symptoms, previous illnesses, medications, family and social relationships, health risk issues—in short, everything that bears on your patient's life and mental health problems) and a *mental status examination* (or MSE, which is an evaluation of your patient's current thinking and behavior).

In the course of this book, I will take you through each section of the history and MSE, in more or less the chronological order you would use when talking with your patient. In separate chapters, I'll discuss the content of the information you should expect to obtain and the interview techniques that are most appropriate to that content. Where it seems appropriate, I will also discuss issues of rapport.

TIME FACTORS

In the first few moments of an initial interview, you will need to accomplish several tasks.

- You should indicate what form your interview will take—how much time it will take, what sort of questions you will ask, and the like.
- You should convey some idea about the sort of information you expect your patient (or other informant) to give you.
- You must create a comfortable and secure environment that will allow your patient as much control as possible, under the circumstances.

Table 1.1 lists the basic material that should be covered by the time you complete your interview. An experienced clinician might take 45 minutes to examine the average patient. A student will probably require several hours to obtain all the relevant information. Regardless of your level of experience, your emphasis should be on collecting the most information possible early in the relationship—before you can become too committed to a diagnosis.

Even a seasoned interviewer occasionally requires more than one session for an initial evaluation, and anyone needs more time for a patient who is unusually talkative, vague, hostile, suspicious, or hard to understand, or for one who has a complicated story to tell. Some patients simply cannot tolerate a lengthy interview, and even those who are hospitalized may have other appointments to keep. Multiple interviews also give a patient time to reflect and to recall material that might have been initially omitted. Of course, if you interview relatives or other informants, you will need additional sessions, plus time to integrate the information from all of your sources.

I realize that with the rush of modern health care, time available is constantly shrinking. So I've expressed as percentages the amounts of time you should plan to devote to the various portions of an average initial interview:

15%: Determine the chief complaint and encourage free speech.

30%: Pursue specific diagnoses; ask about suicide, history of violence, and substance misuse.

15%: Obtain medical history; conduct review of systems; obtain family history.

25%: Obtain rest of personal and social history; evaluate character pathology.

10%: Conduct MSE.

5%: Discuss diagnosis and treatment with patient; plan next meeting.

Your own professional needs may change the focus somewhat. For example, social workers may spend additional time on the personal and social history. (At one time, some institutions and agencies assigned to social workers the responsibility for obtaining the entire social history. Today, we believe that all aspects of the entire history should be gathered by at least one clinician, who can then synthesize this information into a coherent clinical picture.)

Regardless of your profession, I recommend that you try to get the whole story early in the relationship with your patient. After the first few sessions, even experienced clinicians sometimes assume that they know a

TABLE 1.1. Outline of the Initial Interview

- Chief complaint
- History of present illness
  - Stressors
  - Onset
  - Symptoms
  - Previous episodes
    - Treatment
    - Consequences
  - Course
  - Treatment so far
  - Hospitalizations?
  - Effects on patient, others
- Personal and social history
  - Childhood and growing up
    - Where born?
    - Number of siblings and position
    - Reared by one or both parents?
    - Relationship with parents
    - If adopted:
      - What circumstances?
      - Extrafamilial?
    - Health as child
    - Problems related to puberty
    - Abuse (physical or sexual)?
    - Education
      - Last grade completed
      - Scholastic problems
      - Overly active
      - School refusal
      - Behavior problems
      - Suspension or expulsion?
    - Sociable as child?
    - Hobbies, interests
- Life as an adult
  - Current living situation
    - Lives with whom?
    - Where?
    - Ever homeless?
    - Support network
    - Mobility
    - Finances
  - Marital history
    - Age(s) at marriage(s)
    - Number of marriages
    - Age(s) at termination(s) and how ended
    - Number, age, sex of children
    - Stepchildren?
    - Marital problems?
  - Sexual preference, adjustment
    - Problems with intercourse
    - Birth control methods
    - Extramarital partners?
    - Physical, sexual abuse?
  - Work history
    - Current occupation
    - Number of jobs
    - Reason(s) for job change(s)
      - Ever fired?
- Life as an adult *(cont.)*
  - Leisure activities
    - Clubs, organizations
    - Interests, hobbies
  - Military service
    - Branch, rank
    - Years served
    - Disciplinary problems?
    - Combat?
  - Legal problems ever?
    - Criminal record?
    - Litigation
  - Religion
    - Denomination
    - Levels of interest
- Medical history
  - Major illnesses
  - Operations
  - Nonmental medications
  - Allergies
    - Environmental
    - Food
    - Medications
  - Nonmental hospitalizations
  - Physical impairments
  - Risk factors for HIV/AIDS?
  - Adult physical or sexual abuse?
- Review of systems
  - Changes in appetite
  - Head injury
  - Seizures
  - Chronic pain
  - Unconsciousness
  - Premenstrual syndrome
  - Review for somatization disorder
- Family history
  - Describe relatives
  - Mental disorder in relatives?
- Substance misuse
  - Type(s) of substance(s)
  - Duration of use
  - Quantity
  - Consequences
    - Medical problems
    - Loss of control
    - Personal and interpersonal problems
    - Job difficulties
    - Legal consequences
    - Financial problems
  - Misuse of medications
    - Prescription
    - Over-the-counter
- Personality traits
  - Lifelong behavior patterns
  - Violence
  - Arrests
- Suicide attempts
  - Methods
  - Consequences
  - Drugs or alcohol associated?
- Suicide attempts *(cont.)*
  - Seriousness
    - Psychological
    - Physical
- Mental status exam
  - Appearance
    - Apparent age
    - Race
    - Posture
    - Nutrition
    - Hygiene
    - Hairstyle
    - Clothing
      - Neat?
      - Clean?
      - Type/fashion?
  - Behavior
    - Activity level
    - Tremors?
    - Mannerisms and stereotypies
    - Smiles?
    - Eye contact
  - Speech clear?
  - Mood
    - Type
    - Lability
    - Appropriateness
  - Flow of thought
    - Word associations
    - Rate and rhythm of speech
  - Content of thought
    - Phobias
    - Anxiety
    - Obsessions, compulsions
    - Thoughts of suicide
    - Delusions
    - Hallucinations
  - Language
    - Comprehension
    - Fluency
    - Naming
    - Repetition
    - Reading
    - Writing
  - Cognition
    - Orientation
      - Person
      - Place
      - Time
    - Memory
      - Immediate
      - Recent
      - Remote
    - Attention and concentration
      - Serial sevens
      - Count backwards
    - Cultural information
      - Five presidents
    - Abstract thinking
      - Similarities
      - Differences
    - Insight and judgment

patient well and ignore certain vital information that may have escaped them.

Of course, just as no one has unlimited time, no evaluation can ever be considered complete. As long as you continue to care for your patient, you will be adding new facts and observations to your original database. But if you have done your job well in the beginning, these will largely be matters of corroborative detail that won't substantially affect diagnosis or treatment.

Many patients seek help for serious problems that they find frightening, overwhelming, or even life-threatening. You should elicit their stories in such a way that they feel they have received a complete, fair, professional evaluation. If your patient is unusually dramatic, slow, or discursive, try to understand this behavior in the light of the stresses and anxieties anyone might face, and allow additional time.

SETTINGS

The first moments any professional person spends with a new patient set the tone for all subsequent interactions. Careful attention to such simple matters as introductions and the patient's comfort and sense of control helps establish a relationship grounded in respect and cooperation. If you have your own private office, you can decorate it as nicely as you choose, but institutional offices are often less than regal. Fortunately, the effectiveness of the interview is not related to the elegance of the surroundings. Though a measure of privacy will yield the most information, I have seen excellent interviews done at the bedside, or even in a corner of a busy hospital day room. What's paramount is your concern for the patient's comfort and privacy.

Make the best of what you have available. Sitting across a desk from the patient, as is traditional in so many offices, creates an inflexible barrier between the two of you. It doesn't allow leeway to give more space to the suspicious patient or to draw nearer someone whose depression requires the close comfort of another human being. Try instead to arrange your chairs so you can face the patient across the corner of a desk or table. That way, you can vary the distance between the two of you, as the needs of the moment indicate. If you are right-handed, you can more comfortably take notes if the patient sits to your left. Of course, two chairs that directly face one another will work well, too. By the way, try to have available a box or pocket pack of facial tissues. You never know who in the room is going to need one.

At the same time, you have another duty—one whose importance I won't have to spend any time at all trying to sell. That task is maintaining

your own safety. The vast majority of mental health encounters are uneventful, but in rare cases something untoward happens that results in harm to the clinician, the patient, or both. (In 2006 Wayne Fenton, a psychiatrist who specialized in the management of schizophrenia at the National Institute of Mental Health in Bethesda, Maryland, was beaten to death by one of his patients—an attack that made headlines across the country.)

It should become instinctive with you that at the beginning of every patient interview, you check to ensure your own safety and that of others. Practically speaking, this means following three principles: (1) Interview in a place where there are others nearby; (2) have available an easily triggered emergency alert system, such as an alarm bell; and (3) when you are conducting an interview in a closed office, seat yourself so that you are closer to the door than the patient is, with no desk or other furniture that could hinder a speedy exit if one should become necessary.

Regardless of where you interview, your own appearance can affect your relationship with the patient. What's considered professional may depend somewhat upon the region where you work and the customs of your particular clinic or hospital. This observation may seem obvious, but it bears repeating: You will be perceived as more professional if you pay attention to your dress, grooming, and manner.

OK, standards may have changed a bit over the past decade or two, but dress can still make a difference. In general, patients readily accept conservative clothing and hairstyles; excessively casual dress or manners may suggest nonchalance about the importance of your meeting. Indeed, a 2005 survey revealed that by huge margins, patients preferred physicians to be formally dressed and were more inclined to reveal personal information to clinicians who wore white coats than to those who were casually attired. Most of the patients also stated that they were more likely to follow the advice of someone who was professionally attired. The patients surveyed were on average middle-aged; though teenagers and children could yet prove to be significant exceptions to this rule, the report bears careful consideration. (It is probably relevant to other health care personnel as well.)

Although most mental health clinicians don't wear white coats, clothing that is neat, clean, and not too casual will advertise your status as a professional. Limit any jewelry to something modest; don't antagonize someone whose cooperation you need with adornments that suggest wealth or status the patient could never hope to achieve. If you wear pins, pendants, or items of clothing that indicate a religious affiliation, consider whether any of your prospective clients might regard them as a barrier to an effective relationship. Observe how other professionals in your setting dress and behave; their examples can help you judge what's appropriate.

BEGINNING THE RELATIONSHIP

Introduce yourself, offer to shake hands, and indicate the seating arrangement you prefer. (At a patient's bedside, always sit down, even if you intend to stay for only a few minutes. Even if you have a plane to catch, you don't want to appear too hurried to take time with the patient. Besides, if you're a patient lying in bed, it's uncomfortable to have someone staring down on you.) If you happen to be late for the interview, acknowledge it with an apology. Is your patient's name an uncommon one? Be sure that you have pronounced it correctly. If this is the first time you have met, explain your status (student? intern? consultant?) and the purpose of this interview. What do you hope to learn? What information do you have already? Try to give your patient an estimate of how much time you expect to spend together.

Often you will already know something about the patient from case notes of previous workers, from a hospital chart, or from a physician's referral. You can save time and increase the accuracy of your assessment by reviewing this material before you begin. However, for most of this book, we'll assume that you have no access to such information.

Although some interviewers try to ease into a relationship with small talk, I usually recommend against it. In most cases your patient has come for treatment because of troubling problems. Comments about the weather, baseball, or television shows may seem a distraction or, worse, an expression of unconcern on your part. It seems better to go right to the heart of the matter.

Should you feel that you must start with small talk, ask a question that demands more than a yes–no response. For example:

"How was the traffic coming here?"

"How have you been enjoying the summer months?"

If nothing else, such a question shows that you expect active participation. Especially during the early part of your interview, you want to encourage the patient to elaborate, not to answer "yes" or "no" while you do most of the work. (We'll further consider this and other aspects of interview control in Chapters 4 and 10.)

Occasionally a relative or close friend will want to accompany the patient into the interview room—a situation to which you can respond in either of two ways. I prefer to see patients and informants separately, because it maximizes the amount of information I obtain. To reinforce the patient's sense of autonomy, I almost always start with the patient, advising the informant that "you'll be next." Occasionally, however, you may need to take the other tack and see patient and informant together.

That can happen when the patient is severely impaired, such as with an advanced case of dementia. Then having the relative in the room can be a real time saver. Another occasion on which you'll need the dual-interview format is when the patient strongly requests it, such as when a person with severe anxiety or depression requires extra support.

TAKING NOTES

In most cases you will want to take notes. Few of us can remember even briefly all the material we hear, and you may not have the opportunity to write up your interview right away. So point out that you will be taking notes, and make sure that this is all right with the patient.

Nonetheless, you should try to keep note taking to a minimum. This will allow you to spend more time observing your patient's behavior and facial expressions for clues to feelings. You won't be able to get everything down on paper or to write complete sentences (other than the chief complaint, which we'll discuss in the next chapter). Instead, jot down key words that can indicate which issues to explore later or that can serve as reminders when you write up your report. Try to keep your pen in hand; this avoids the distraction of repeatedly picking it up. You can lay it aside when you discuss especially sensitive topics that the patient might not care to have recorded.

This brings up the vexed question of computerized records. With our record systems increasingly online, even in the cloud, we clinicians face pressure to keyboard information as we talk with our patients. I confess that I simply cannot imagine an effective way of doing this while talking with a new patient, if we are to have any hope of creating good rapport. For me, the answer *still* seems to be to take notes with a pencil, and write up the summary later. This position seems to resonate with colleagues—some of whom point out that with the advent of increasingly accurate dictation programs, even those of us who type at the hunt-and-peck level can enter digital information efficiently.

Now here's another problem: Sometimes a patient will ask that you keep certain material out of the chart. If you're a student, no problem. But if this request comes early in your relationship as the responsible clinician, it is usually better to comply, especially when it only applies to a limited portion of the interview. If the patient seems extremely uncomfortable with any note taking, you can explain that you will need some notes for later review to help make sense of it all. In the rare event that the patient insists, give in, put down your pen, and later transcribe all that you can remember. What you want is to complete an informative interview, not to win a contest of wills. However, at some point—perhaps not right now when you are trying to complete the interview—you might raise the point

again. Having a significant hole in the database could prove problematic, especially if this patient will be seen by other clinicians later.

Reviewing an audio recording of a session can help you spot difficulties in your interview style. You can often uncover deficiencies that you would have missed with a less faithful record of your conversation. As an everyday practice, however, it has drawbacks: Reviewing a recording takes a lot of time, and some patients may feel even less comfortable with recording than with note taking. If you do decide to make an audio recording, begin only after you have explained its educational purpose and obtained permission.

You may also need to explain that state laws and professional ethics could require you to report certain information that has a bearing on the safety of others. This principle, formalized in California in 1974 by the *Tarasoff* decision, clearly states that health care personnel have a duty to protect identifiable persons against whom threats have been made. Although not all states have enacted such a statute, clinicians everywhere are advised to behave as if it has been enacted. Of course, if you are a student, you should never take such action on your own; discuss at once any threats or other concerns you have with a supervisor, who will then take the lead in fulfilling the duty to protect.

SAMPLE OPENINGS

Effective openings have many possible variations. Here is a good one.

INTERVIEWER: Good morning, Mr. Dean. I'm Emily Watts, a third-year medical student. I'd like to talk with you for about an hour to learn as much as I can about people with problems like yours. Do you have the time to spend with me now?

PATIENT: Yes, that will be fine.

INTERVIEWER: Why don't you sit right here? (*Motions toward a chair.*) Do you mind if I take some notes?

PATIENT: No, everyone else seems to.

This opening works because it quickly conveys information that is important to the patient: the interviewer's name and position, the purpose of the interview, and the time that will be required. The interviewer also manages the business of seating arrangements and obtaining permission for note taking. However, some patients may bridle at the notion of having a problem. Ms. Watts was interviewing an established patient, so her question went unchallenged. New patients might respond better to a simple "Please tell me why you are here."

Here's another useful opening:

PATIENT: Are you the student they told me about?

INTERVIEWER: No, I'm Dr. Holden, a psychology intern. I spoke with your therapist earlier this afternoon, and I'd like to spend some time with you to see what we can do to help you out. We can use this little room.

PATIENT: (*Nods.*)

INTERVIEWER: To help you best, I'm going to need all the information I can get. I'd like to jot down a few notes, if that's all right with you.

PATIENT: No problem.

Sometimes the information-gathering phase takes more than a single interview. You might start the follow-up session by saying, "Have you thought of anything more to say from our previous discussion?" or "What did you say to your [husband, daughter, etc.] about our last meeting?" Otherwise, just pick up where you left off last session when time ran out.

CHAPTER 2

Chief Complaint and Free Speech

The chief complaint states the patient's reasons for seeking care, whereas the free speech that immediately follows encourages the patient to talk about all these reasons. The words you use to prime the information pump can greatly affect your subsequent yield, and they fall into one of two principal interviewing styles: directive and nondirective.

DIRECTIVE VERSUS NONDIRECTIVE QUESTIONS

By asking many specific questions, a directive interviewer explicitly provides the structure that tells the patient what sort of information is wanted. The nondirective interviewer more passively absorbs whatever information the patient chooses to present. A nondirective style usually yields strong rapport and reliable facts. However, an exclusively nondirective style also produces less information. For example, without direction, the patient may not realize that family history is important or could feel too embarrassed to volunteer highly personal information. A maximally effective initial interview will use both nondirective and directive questions.

Most of the early portion of your interview should be nondirective. This helps you establish your working relationship and learn what sorts of problems and feelings are uppermost in your patient's mind. But your opening request for information should clearly state what you expect of your patient.

THE OPENING QUESTION

When you ask your first question, be specific. Let your patient know exactly what you want to hear about. If, like some nondirective interviewers, you leave matters completely up to the patient ("What would you like to talk about?"), you could end up with quite a lot of information about last Sunday's football game or the patient's new sports car. Eventually you would get the interview back on track, but at the cost of time and perhaps rapport with a patient who might wonder whether you knew what you really wanted.

You can avoid these difficulties by asking the right sort of question in the first place:

"Please tell me what problems made you come for treatment."

For most patients, this will serve very well. Once in a while, however, you'll run into someone who resents the notion that there is a problem. Of course, you could bypass the difficulty by asking, "Please tell me why you are here," or "Why did you come for treatment?" For some individuals, each of these carries seeds of discontent: Teens often don't come of their own volition, and you'll encounter occasional patients whose goal is simply to find meaning in their lives. In the end, there's no perfect opening. If your patient objects to your opening gambit ("There's nothing wrong with me!"), you can usually fix the situation with the response, "Perhaps you could just tell me your idea of why you are here."

Whatever the exact content of the question, notice that the sample opening requests have two qualities that affect the type of information you will obtain:

- It tells the patient just what sort of information you seek.
- It is also open-ended. Open-ended inquiries are questions or statements that cannot readily be answered in a word or two. Because they invite patients to talk for a while about what seems important to them, they promote a relaxed interview style early in the interview that helps build rapport.

Open-ended questions and statements can serve two functions. Some simply request more information about a point:

"I'd like to hear some more about that."

"Could you expand on that?"

"What else happened?"

Others also move the story along toward the present:

"What happened after that?"

"And then what?"

"What did you do next?"

Open-ended requests can broaden the scope of information you obtain; with more freedom to respond, patients tell you what's important to them. They let patients know that their stories matter to you. They also allow you to spend less time talking and more time observing. The value of this will become more evident in Chapter 11 when we talk about the MSE.

Closed-ended questions more narrowly direct the sort of answer desired and can be answered in a few words. They can be "yes–no" or limited-choice questions ("Where were you born?" as opposed to "Tell me about your childhood"). They, too, are useful; they are sometimes necessary to obtain the most information in the least time. But in early parts of the interview, use open-ended questions that will encourage your patient to tell a story that touches on as many aspects of the case history as are relevant.

THE CHIEF COMPLAINT

The *chief complaint* is the patient's stated reason for seeking help. It is usually the first full sentence or two of the reply to your opening question:

"Tell me about the problem that brought you here."

Importance

The chief complaint is important for either of two reasons.

1. Because it is usually the problem uppermost in the patient's mind, it suggests an area to explore first. Most patients have some sort of a specific problem or request. Here are some samples:

"I can't reach my goals."

"I have trouble forming relationships with women."

"I hear voices."

"I'm so depressed I feel that I can't go on."

Each of these typical examples expresses some discomfort, life problem, or fear that the patient wants help with.

2. By contrast, sometimes the chief complaint is a flat denial that anything is wrong. When this is the case, it tips you off about your patient's insight, intelligence, or cooperation. For example:

> "There's nothing wrong with me. I'm only here because the judge ordered it."
>
> "I don't remember anything about it."
>
> "Absolute zero is coming, and when it gets here my brain is going to turn to bread."

Chief complaints like these three indicate serious pathology or resistance that requires special handling. In Chapter 16 we'll discuss patients who resist being interviewed.

Responding

Some chief complaints suggest that your patient doesn't quite understand the purpose of the interview. You will sometimes encounter this sort of vague or slightly quarrelsome chief complaint, so you should be prepared with some good responses.

> INTERVIEWER: Why did you come here for treatment?
>
> PATIENT: You can read all about it in my record.
>
> INTERVIEWER: I could, but it would help me learn more about you if you'd tell me in your own words.

Here's how one interviewer reacted to a patient who, instead of a complaint, gave a prescription:

> PATIENT: I think I just need some vitamins.
>
> INTERVIEWER: Perhaps, but let's decide that after you tell me what's been bothering you.

Another patient made a plea for help in getting started:

> PATIENT: I really don't know where to begin.
>
> INTERVIEWER: Why don't you start with when your most recent trouble began?

Try to Learn the Real Reason for Coming

A patient's first words don't always express the real reason for seeking help. Some patients don't recognize the real reason; others may feel ashamed or fearful of what they'll be told. In either case, the stated chief complaint may be only a "ticket of admission" to the help a clinician can provide:

"I've been in such pain." (But the real pain is emotional.)

"I feel anxious nearly every moment I'm awake." (Heavy drinking is avoided.)

"I'd like to discuss some of my relationships." (The patient is afraid to mention HIV/AIDS.)

"I want some advice about my mother. I wonder if she's becoming senile." (The patient really wonders, "Am I going crazy?")

Each of these initial complaints masks a deeper, less obvious reason for seeking help. Often you can ferret out the real problem later in the interview by asking:

"Is anything else bothering you?"

Sometimes you might determine your patient's underlying motivation only after you think you've completed your initial evaluation.

Regardless of what chief complaint is presented, you should write it down in your patient's exact words. Later, you will want to contrast it with what you believe prompted the patient to seek help.

FREE SPEECH

During the few minutes following the chief complaint, your patient should have the chance to discuss freely the reasons for seeking treatment. To encourage the widest possible range of information, allow the story to emerge with little detailed probing or other interruption from you. We'll call this nondirected flow of information *free speech*, to distinguish it from the relatively constrained question-and-answer format of the later clinical interview.

What Is Free Speech?

Free speech, simply put, is just an opportunity for patients to express their thoughts without constraint or direction. "Speech with a minimum of

structuring" is how some clinicians would put it. Experienced interviewers recommend this period (as much as 8 or 10 minutes in an hour-long session) of free speech for several reasons. Some of them are the reasons for asking any open-ended question:

- Free speech establishes you as someone who cares enough to listen to your patient's concerns.
- It provides the patient an opportunity to organize and explore the reasons for seeking treatment.
- You have the opportunity to learn what is uppermost in your patient's mind.
- It gives you the flavor of the patient's personality.
- Unhampered by any need to direct the conversation, you can start making observations about mood, behavior, and thought processes.
- Character traits may be more likely to emerge in a person who is speaking spontaneously than in one who is answering a stream of questions.
- When you share control during this portion of the conversation, you establish early the expectation that your patient will be an active partner throughout therapy.
- You can devote close attention to the content of your patient's speech. One study showed that as many as half the total symptoms reported by patients are mentioned in the first 3 minutes of an initial interview.
- It provides your patient an opportunity to bring up other concerns that weren't mentioned in the chief complaint.

Most patients will respond quickly and appropriately to your request that they talk about their problems. Getting them to tell you everything you need to know will take little redirection on your part. Some have had so much experience telling their stories that they give you complete, chronological accounts of their illnesses.

The opposite may be true of others, some of whom may have experienced too many interviewers who want only specific answers to closed-ended questions. You may have to teach these patients to give you an expanded version of their feelings and experiences. If your patient persistently makes brief statements, then waits for more questions from you, you should explicitly state what you expect. For example:

> "What I'd really like is for you to tell me in your own words about your problem. Later I'll ask some specific questions that you can answer briefly."

In fact, few histories unfold like a classic textbook account of a mental health problem. Patients have their own ideas about what is important, and, regardless of the apparent value of their information, it is important that you let them make a stab at telling their stories. An occasional patient with low intelligence or severe psychosis might not be able to give a satisfactory narration. Then you'll have to fall back on a much more structured, question-and-answer strategy to obtain any history. But these patients will be infrequent, and everyone who speaks at all will at least give you information in the form of the mental status observations you can make.

Allowing patients time to speak freely is at least as important now as it has ever been, but health care reimbursement models have put an ever-tightening squeeze on clinicians' time. It threatens to crowd out all but the most basic clinical interactions, tempting an interviewer to cut directly to the chase and focus too quickly on a patient's very first words. I know this because I've done it—and must occasionally remind myself of the importance of a prolonged period of free-running speech. If I do find that I've allowed too little time at the outset for free speech, I'll try to slip it in later on.

AREAS OF CLINICAL INTEREST

During free speech, your patient will probably mention one or more problems. These concerns can be emotional, physical, or social; most will fall into one of several major areas of clinical interest. When people become mental health patients, it is usually because of problems covered by these seven areas:

Difficulty thinking (cognitive problems, especially what DSM-5 now calls neurocognitive disorders)

Substance use

Psychosis

Mood disturbance (depression or mania)

Excessive anxiety, avoidance behavior, and arousal

Physical complaints

Social and personality problems

Each area of clinical interest comprises a number of diagnoses that have symptoms in common; of course, some of these diagnoses turn up in more than one area. Later, when you obtain the history of the present illness, you will systematically ask about the symptoms usually

associated with each of these areas you have identified. This information will allow you to determine which of the associated diagnoses seems appropriate for your patient. But for now, during free speech, just make a note (mentally or on paper) about any subject that seems worth exploring later.

Signaling Areas of Clinical Interest

A number of symptoms and items of historical information specific to each area of clinical interest signal the need for further exploration. When you encounter one in your interview, consider an intensive review of that area (discussed in Chapter 13). These "red flag" symptoms are summarized in Table 2.1.

HOW MUCH TIME?

Unless your patient's speech is unusually vague or rambling, the chief complaint usually takes only a few seconds. However, the time you devote to free speech can vary tremendously. In the rare event that your patient is incoherent or nearly mute, you might decide within moments to adopt a more directive interview style. But with a patient who is experienced, well organized, and motivated to tell all, you could conceivably spend an entire interview in free speech, listening to a history that is presented just the way you would read it in a textbook.

Most patients will be neither of the above. Sometimes you can listen without much interruption for the first 5 or 10 minutes. But don't try to stick to this recommendation too strictly; your allotment to free speech will depend on the total time you can spend interviewing and on what you already know about the history. As a rule, you should allow your patient to speak freely as long as the information you obtain seems important and relevant.

MOVING ON

The free-speech portion of the interview will draw to a close as you sense that you have obtained a broad outline of the problems that are uppermost in your patient's mind. Before proceeding to the next section of your interview, you should ask whether there are problems other than those already mentioned. This decreases the risk that you will overlook vital problem areas. (Even if you missed something big, it would probably show up later. Yet the whole point of the initial interview is to try to get as much relevant information as possible up front.)

TABLE 2.1. Problems That Signal Areas of Clinical Interest

- Difficulty thinking (cognitive problems)
  - Affect fluctuates
  - Bizarre behavior
  - Confusion
  - Decreased judgment
  - Delusions
  - Hallucinations
  - Memory defects
  - Toxin ingestion
- Substance misuse
  - Alcohol use heavier than one or two drinks per day
  - Arrests or other legal problems
  - Financial: spending money needed for other items
  - Health: blackouts, cirrhosis, abdominal pain, vomiting
  - Illegal substance use
  - Job loss, tardiness, demotions
  - Memory impairment
  - Social problems: fights, loss of friends
- Psychosis
  - Affect that is flat or inappropriate
  - Bizarre behavior
  - Confusion
  - Delusions
  - Fantasies or illogical ideas
  - Hallucinations (of any of the senses)
  - Insight or judgment that is disturbed
  - Muteness
  - Perceptual distortions (illusions, misinterpretations)
  - Social withdrawal
  - Speech that is hard to follow or incoherent
- Mood disturbance: depression
  - Activity level that is either markedly increased or decreased
  - Anxiety symptoms
  - Appetite changes
  - Concentration poor
  - Death wishes
  - Feelings of worthlessness
  - Interest decreased for usual activities (including sex)
  - Sleeplessness or excessive sleepiness
  - Substance misuse recently increased
  - Suicidal ideas
  - Tearfulness
  - Weight loss or gain
- Mood disturbance: mania
  - Activity level increased
  - Distractibility
- Mood disturbance: mania *(cont.)*
  - Grandiose sense of self-worth
  - Judgment deteriorating
  - Mood that is euphoric or irritable
  - Plans many activities
  - Sleep decreased (reduced need for sleep)
  - Speech rapid, loud, hard to interrupt
  - Substance misuse recently increased
  - Thoughts moving rapidly from one idea to another
- Anxiety and related disorders
  - Anxiety
  - Chest pain
  - Compulsive behavior
  - Dizziness
  - Fear of going crazy
  - Fear of dying or impending doom
  - Fear of objects or situations
  - Heaviness in the chest
  - Irregular heart beat
  - Nervousness
  - Obsessional ideas
  - Palpitations
  - Panic
  - Shortness of breath
  - Sweating
  - Trauma: history of severe emotional or physical
  - Trembling
  - Worries
- Physical complaints
  - Appetite disturbance
  - Convulsions
  - Depression, chronic
  - Headache
  - History that is complicated
  - Multiple complaints
  - Neurological complaints
  - Repeated treatment failures
  - Sexual or physical abuse during childhood
  - Substance misuse
  - Vague history
  - Weakness
  - Weight changes (up or down)
- Social and personality problems
  - Anxiety
  - Behaviors that seem odd or bizarre
  - Dramatic presentation
  - Drug or alcohol misuse
  - Job loss, tardiness, demotions
  - Legal difficulties
  - Marital conflict

This is also a good time to check on your understanding of all problems. Briefly summarize each, and invite your patient's assessment of your analysis.

INTERVIEWER: Let's see if I have this right. You felt just fine until about 2 weeks ago, when you proposed to your girlfriend, and she accepted you. Since then you've had increasing attacks of anxiety, you've felt depressed, and you can't concentrate on your studies. Now you're afraid you might have heart disease because your pulse races. Is that about right?

PATIENT: That's pretty much it.

INTERVIEWER: I want to learn more about that—but first, is there anything else that's been bothering you?

And for those patients who present multiple complaints, it can sometimes be useful to ask, "Which of these problems bothers you the most?" At a minimum, such a question can provide focus for later summaries and discussions of treatment.

CHAPTER 3

Developing Rapport

Rapport is the feeling of harmony and confidence that should exist between patient and clinician. As one of the goals of a good interview, good rapport has practical consequences. This point is especially relevant if you will be treating this patient in the future. The trust and confidence you begin to develop even in the opening minutes of the first session can greatly enhance your ability to manage a course of therapy. In fact, how well you convey your interest is the factor most likely to keep your patient in treatment.

But good rapport is also vital for obtaining information. During the evaluation phase of your relationship, positive rapport will help motivate your patient to talk spontaneously and to reveal important personal data.

The foundation for rapport is usually ready-made. Most patients come looking for help and expect that they will get it from a clinician. You can build on this expectation with your words and body language, which should express real interest in the patient. Of course, anyone could inadvertently say something that's upsetting, but there is little you are likely to say or do that can't be retrieved if you remain caring and sensitive to what your patient is experiencing.

THE BASIS OF RAPPORT

Right from the start, most patients will expect to like you. But real rapport between two individuals doesn't usually spring up overnight. It develops gradually, with long acquaintance and the cooperation of both parties. Still, you can use certain behaviors to speed its growth.

Your demeanor is key. Remember that professionalism doesn't demand stiff formality. In fact, you should take care to avoid the image of

the stone-faced therapist that was once popular in movies, cartoons, and fiction. If you appear relaxed, interested, and sympathetic, your patient is more likely to feel safe and comfortable. Carefully monitor your facial expression: Don't frown, grimace, or show other signs of negativity that could be interpreted as disapproval. Although you should avoid fixed stares, which can make you appear cold and critical, be sure to make frequent eye contact—even if you are taking notes. Of course, you don't want to appear insincere, but appropriate smiles and nods will demonstrate that you are attentive and sympathetic.

Just at first, however, I'd be a bit sparing in the use of praise. Praise used as a reinforcer can powerfully shape behavior, but early in any relationship, you don't know enough to be sure what behavior you will be reinforcing. For instance, you wouldn't want to praise apparent openness if your patient hasn't told you the whole truth.

The patient's own demeanor will probably shape your interaction more than any other factor. Body language—drooping shoulders, restless feet, tears, a clenched fist—often clearly indicates how your patient feels. Observe tone of voice for other clues to feelings. Suppose you have asked your patient, Mr. Kimble, how he and his wife get along, and he responds, "Just fine." If his tone is warm and light, the couple probably has relatively few interpersonal problems. If his "Just fine" is delivered through clenched teeth, in a dull monotone, or with a sigh, Mr. Kimble may be harboring feelings of hopelessness or anger that he can't put into words just yet.

Because you have arranged the furniture so that there's no barrier between you and your patient, you can easily and naturally adjust even to minor shifts in affect, promoting rapport. If your patient is depressed, you will probably feel like drawing a little closer to show your concern. You can follow that natural inclination. If you sense hostility, you may feel like withdrawing physically, even if only a few inches. Doing so will help relax the tension by giving each of you more elbow room. Similarly, you may laugh when your patient makes a joke, or display a worried frown of concern and support during a panic attack. By the time you have interviewed your first dozen patients, you will do these things automatically in response to the cues each patient unconsciously gives.

At the same time, you should carefully maintain a certain neutrality toward what you are told. If your patient criticizes relatives, you would be unlikely to defend them. But joining in the criticism risks offending someone whose feelings may be ambivalent. A safe response is an empathic comment that doesn't take sides.

PATIENT: My mother is a real bitch! She keeps trying to interfere between me and my husband.

INTERVIEWER: *(Leans slightly forward.)* That must be a real problem for you.

This interviewer's attitude—sympathetic, nonjudgmental, and respectful of patient and relatives alike—is likely to foster a good working relationship.

ASSESS YOUR OWN FEELINGS

How you feel about the patient can have important consequences. If your feelings are positive—here is the sort of person you might choose as a friend, for example—you will probably come across as warm and caring. Your attitude may serve as an encouragement to reveal additional sensitive information.

Heavily influenced by your own background and upbringing, your feelings could in turn affect your ability to make an accurate evaluation. Throughout the interview, you need to be aware of the nature and the sources of your feelings, especially when something about the patient distresses you. It could be as simple as personal hygiene, coarse language, or the expression of ethnic prejudice. Or does this person remind you of difficulties you had with one of your own relatives? In any case, you must carefully monitor how you respond. If you frown or otherwise appear uncomfortable, your patient may sense your disapproval and frustrate your efforts to gather accurate information.

Your goal is to express *empathy*, which means that on some level you can feel as your patient feels—that you can put yourself in the patient's place. Having empathy means understanding the motivation driving a patient's behavior, even if it still doesn't seem like the right thing to do. Showing your empathy sparks confidence in the process and encourages the patient to give you the diagnostic information you need. (Surveys show that mental health clinicians score much higher than do other health care professionals in the ability to adopt another person's perspective.) You will probably convey your empathic feelings best if you keep in mind this thought: "What would it be like to stand in the shoes of this patient talking with me now?"

This job might seem daunting when your patient shows a lot of anger, anxiety, or even psychosis. Throughout your professional life, you will have to work with all sorts of people. Some of them will seem less agreeable than others, but you will find that nearly every patient will have characteristics to which you can relate. If you cannot respond positively to the content of what you are being told, perhaps you can sympathize with some of the feelings behind it. For example, a moderately antisocial patient was speaking about his former therapist:

PATIENT: I had no use for that guy. Once or twice I even thought about blowing him away!

INTERVIEWER: Sounds as if you were feeling really angry.

Trying to deal directly with the content of this patient's comment would have forced a choice between agreeing with or confronting a potentially violent patient. By keying into the patient's anger, this interviewer said something that both parties could feel comfortable with.

All professionals have feelings, attitudes, and experiences that can affect the image they project; we must all be constantly alert to prevent these personal issues from impairing our effectiveness with patients. Consider the effect of so ordinary an event as divorce:

> One clinician found that she was so upset during the time she was separating from her husband that she could not effectively manage a patient who was having similar problems.
>
> Another therapist, after a bruising telephone call from his ex-wife, postponed his next interview while he cooled off enough to focus on the patient's problems.

Many beginning interviewers have learned that they can alleviate pressure if they introduce themselves to patients as students. But regardless of your stage of training or practice, your temperament and experience will determine how you deal with your personal Achilles' heel. Whatever it is, your effectiveness with patients will increase if you remain aware of your own limitations.

CONSIDER YOUR MANNER OF SPEAKING

For good rapport, the patient must know that you understand. It is tempting to approach this directly by saying, "I know how you must feel about . . ." Unhappily, this statement can ring hollow. By the time they reach your office, many patients have heard it all too often from people who don't really understand at all, or who may understand perfectly but do nothing to help. Some patients with severe problems, real or perceived, feel that nobody could possibly appreciate what they are going through. You will probably be better off using some other response to suggest your compassion and interest:

> "You must have felt terribly unhappy."
>
> "I've never been in that position, so I can only imagine how you felt."
>
> "That was a terrible experience. I can see that it upset you a great deal."

Sometimes you may find that you need to overemphasize your feelings a little. This suggestion might sound deceitful, but I don't mean it that way. Actors, for example, know that their recorded voices tend to

flatten out and that they must overact to get across the feelings they in tend to portray. In similar fashion, you may need to amplify your own emotional output to impress upon some patients how deeply you sympathize with them. You can accomplish this with your facial expressions, or with your voice by varying its volume, pitch, and emphasis. Even brief exclamations can do the job. An "Oh, wow!" that is suitably timed and intoned may convey understanding and compassion more effectively than a more elegant speech of condolence. Such emblems of your emotional involvement, which beginning interviewers often forget to use, can be vital to your patient and contribute to building rapport.

However, it's far too easy to go overboard. Consider the patient who comes to you with a story of betrayal by a lover, or of injury in a military or civilian calamity. Of course, you will want to show your support, but if you express your own shock or horror too starkly, you risk reinforcing the traumatic effects you're there to dismantle. Sure, go ahead and express sympathy—you can even provide the support of a proffered tissue—but be careful not to portray your patient as a victim.

Now let's consider the use of humor in your interactions with patients. Humor can be a great facilitator of communication: It helps people to relax and to feel that they are among friends. But as a clinician, take care to judge your use of humor carefully. With any recent acquaintance, it is easy to misjudge and say something in jest that can be taken amiss; mental health patients are especially vulnerable to this sort of slip. Even a patient you know well could misinterpret an ill-considered remark. As always, put yourself in the patient's place: Consider how you'd feel if you thought your clinician was laughing at you.

In general, it is safe to laugh with, but of course never at, the patient. That means that you should generally let the patient start it. During your first few sessions, any use of humor should be gentle, and only when it is clear that the patient is in a frame of mind to appreciate it. Beware of making jokes, which might be misinterpreted as hostile or demeaning. Whenever the patient jests, be sure to consider whether this is a subconscious attempt to sidetrack both of you from a discussion of important material. A usually safe response is to smile and meet the patient's gaze.

Experienced interviewers report that they sometimes seemingly undergo a personality change as they move from one patient to the next. They may adopt a formal tone with one, then settle into a folksy persona with the next. One interviewer persistently, and quite unconsciously, dropped his *g*'s when talking with a patient from a rural background who spoke that way. Within limits these behaviors are probably acceptable, though you should be careful not to overdo them to the point of mimicry.

Regardless of your level of experience, at some point, with some patient, you will make an error. In the greater scheme of things, it will probably be of rather minor significance—you ask the same question

twice; you forget the occupation of your patient's spouse; or you are suddenly aware that your mind has drifted and you can't recall the question your patient has just asked (or that you have!)—but both of you know that you've erred. You should take immediate steps to put it right. "Uh-oh, senior moment," I might say with a rueful smile. If you aren't so fortunate as to have age as an excuse, you should admit that you focused for a moment on something else, and do whatever is necessary to correct your error (for example, ask the patient to restate the question). Almost always, the conversation will move safely forward. The important thing is to let the patient know you've taken responsibility for the mistake and that it matters to you.

TALK THE PATIENT'S LANGUAGE

Take pains to speak in terms your patient can understand. Listen to your patient's language and use it, as long as you feel comfortable doing so. Because teenagers and young adults often distrust older people, they may respond more positively if you use language that is current for their generation. But be sure that your "cool" expression is still "in," or you risk being considered merely "square." (There is another point of view on this issue. Some adolescent patients may resent it enormously and become even more distrustful if you try to adopt their speech patterns.) How you speak to any patient should be guided by the need for clarity and rapport, so monitor your patient's reactions and adjust your manner of speaking accordingly.

Certain terms may upset some patients. These loaded words carry a message of illness, failure, or poor character, and you should generally avoid them. Here is a brief sample: *abortion, bad, brain damage, cancer, crazy, defective, fantasy, frigidity, hysterical, impotence, neurotic, obscene, perversion, victim*. You will encounter many more during your interviewing career. Be ready with neutral synonyms for such words, or, even better, pick up on terms your patient already has used.

Avoid psychological jargon. Even simple terms like *psychosis* may be misunderstood, and your patient could think that you seem insensitive toward someone with less education than you. Also ensure that you understand your patient's own use of language; don't assume it is the same as yours. For example, to you "an occasional drink" may mean once a month, but to your patient it could mean "intermittently throughout the day." Does your teenage patient drink *Coke* or snort *coke*? In the language of the street, "I was really paranoid" doesn't mean that the speaker felt psychotically persecuted, but merely frightened.

Your poorly educated patient may recognize "polite" terms for sexual or excretory functions, but the relationship you develop may be better if

you use plain language. I confess to holding conflicting thoughts about using the argot of the street. On the one hand (as some studies have shown), by using everyday terms, you might increase the amount of information you get. On the other hand, the same tactic could risk offending people on whom you depend for accurate information. In the final analysis, you'll have to base your decision on your own comfort level and your assessment of the individual patient.

If your patient is foreign-born or was reared in another part of your own country, you may have trouble understanding one another. Don't let your manner imply that it is the patient who "talks funny." Rather, acknowledge that you have different accents and that at times you may have to ask one another for repetition. For a patient who hesitates or seems unsure of how to proceed, you can remove some of the pressure with the reassurance that "It's fine to take this at your own pace, so I can really understand what you're experiencing." On the flip side, to be sure you *do* understand, you may want to translate into simpler language the sometimes florid terms that patients use to express themselves—perhaps to obfuscate, perhaps because they think a clinician wants to hear psychological terms.

PATIENT: I've always had a phobia about cats—I've got four of 'em.

INTERVIEWER: So you're a real cat fancier!

Later on, perhaps, when you've gotten to know one another better, you can supply an accurate definition.

MAINTAIN BOUNDARIES

How clinicians should relate to their patients has been a moving target over the years. The traditional image of an authoritarian lawgiver who decides *for* the patient has been generally supplanted by that of a less formal collaborator who explores problems and their solutions *with* the patient. I strongly prefer the latter style. To me it feels more comfortable (it is less arrogant), and it encourages the patient to participate in treatment decisions. In effect, it puts two minds to work, rather than loading all the responsibility onto the clinician. When patients discuss and contribute to their own management plans, they are more likely to comply with treatment and less likely to complain about bumps in the road to improvement.

Yet even clinicians who encourage friendly collaboration need to maintain boundaries. When I practiced in California, it was customary to call patients by their first names. For adolescents this seemed just fine. But

I heard even old men and women addressed in this overly familiar manner by mental health professionals young enough to be their grandchildren. This attitude tends to infantilize patients who, if they are hospital inpatients, have already lost considerable autonomy. It also increases the professional person's tendency to become *parentalistic*—that is, to make health care decisions that patients should be making for themselves.

However, before I make *too* big a deal of this, let me note that times have changed and that many therapists have maintained successful practices while they and their patients address one another in familiar terms. I still reject the idea of first names for hospitalized patients, and I continue to call my adult patients by last name and title (Miss, Ms., Mrs., Mr., or Dr. Green). This practice maximizes personal dignity and reinforces a sense of adulthood, even at a time when there may be loss of autonomy. It also encourages patients to keep a certain emotional distance by using my title and last name. This distance may sometimes help head off inappropriate attempts at amorous and other nonprofessional relationships.

If a patient appears offended when I don't agree to a first-name basis, I respond that it is my habit always to use last names and titles, and that it would be hard for me to change. (If you are still a student, your excuse might be that this is what your institution requires of trainees, if that's the case.) Rarely, I have encountered patients who doggedly insist that I use their first names. If I judge that sticking to my habit could harm our relationship, I will use *two* names—first and second or first and last—plus title. For example, when calling such a patient from the waiting room, I will announce, "Mrs. Joanne Cremier," and say it with a big, friendly smile. So far, this compromise has always proven satisfactory. However, other clinicians (and their patients) may feel differently, so there should probably be no hard and fast rule about using names.

In general, it's a good idea not to reveal too much about yourself to your patients. This is especially true during the initial interview, when you really don't know one another very well.

> A beginning psychiatry resident confided to his new patient that he was a reserve peace officer. He later learned to his chagrin that the patient had both a severe personality disorder and an abiding hatred of the police.

If you are having difficulty getting information, you might be able to encourage greater cooperation by identifying something that you and the patient share. For example, you might remark that, just like the patient, you enjoy sailboating or were born in Indiana. Your status as fellow sailors or Hoosiers might nudge you a bit closer to the rapport you seek. This technique should be used sparingly—seldom more than once with a given

patient—lest you begin to sound too familiar. You should also be careful not to let any resulting small talk distract you for long from the real purpose of your interview.

Why do patients ask personal questions? Some stem from simple curiosity; others may cloak concern about interviewers' professional backgrounds or ability to help. To provide reassurance about training and competence is one reason why clinicians in practice display a wall full of diplomas, licenses, and other certificates. Trainees have the benefit of neither certificate nor wall. Still, to whatever degree possible, you should verbally provide this information when it is requested. Don't hesitate to invoke the names and positions of your supervisors if this is needed to reassure an especially anxious patient.

Some requests for personal information may be prompted by a largely unconscious desire to achieve a sense of equality between interviewer and patient. Others may be an attempt to avoid discussing sensitive material, and these should be handled firmly but with tact:

PATIENT: How old are you, anyway?

INTERVIEWER: Why do you want to know?

PATIENT: You seem so young to be doing this kind of work.

INTERVIEWER: Well, thank you for the compliment, but I don't think my age is especially relevant to our discussion; let's focus on you. Now, to get back to the question I asked . . .

In some circumstances, personal information may seem relevant to your interview. If you decide that this is the case, you can usually reveal something of yourself:

PATIENT: Were you raised in this city?

INTERVIEWER: What makes you ask that?

PATIENT: My mother told me to be sure to get a therapist who grew up here. She says no one else could really understand what it was like, growing up in a ghetto and all.

INTERVIEWER: I see. Actually, I didn't grow up here, but this is where I took most of my training. I've lived in town for nearly 8 years, so I think I have a pretty good idea of what some of your experiences must have been. But I have the feeling you'll be able to tell me a whole lot more.

Because I believe it helps build rapport, I tend to answer innocuous questions frankly, so long as it seems unlikely to complicate the relationship later.

SHOW YOUR EXPERTISE

You can pave yet another pathway to rapport by informing the patient that you know something about the presenting symptoms and what they could mean. This assessment will naturally come at the end of the initial interview, when you've obtained enough information to know what you're talking about. Then you'll probably say something like this:

> "Your condition is actually pretty common—one of the most frequent problems patients bring to mental health clinicians. I've seen several similar cases just in the last few months. We have several good treatment approaches available, so we can look for a good outcome in your case."

Even if you are facing a rare condition, you can reassure the patient that you know where to turn for guidance:

> "We can work through this problem together."

If you're a student, you probably won't have had much in the way of personal experience with your patient's condition—or any other. But you are connected with a training program that employs experienced teachers who have encountered many patients with similar conditions.

I would offer a few warnings about showing expertise. First, a natural consequence of empathy is respect, which implies that you should take pains to avoid sounding *authoritarian*. Sounding *authoritative* is fine, if it's accurate, but sounding authoritarian smacks of the old, parentalistic clinical style that seems disrespectful in the 21st century. It never did work all that well, anyway. Second, in your zeal to put your patient at ease, don't succumb to a patient's too-early request for information or advice. Part of being expert is waiting until you have the facts to justify offering support. Jumping in too soon with a diagnosis or with suggestions for treatment sometimes ends in embarrassment and backpedaling down the line. Finally, try to wear your erudition lightly. Preface your opinions with "I think" or "In my experience"—the patient will honor them just as well, and you'll avoid the need to live up to an aura of infallibility that no one can sustain.

Inevitably, you will encounter an occasional patient you just cannot work with. Sometimes this will be due to your own feelings—about unrepentant criminal behavior, perhaps, or about someone who reminds you too strongly of your own former spouse. At other times you'll be tipped off by something the patient says, such as a statement of preference for "a Christian therapist" or some other therapeutic orientation that just plain doesn't fit with what you have to offer.

Such patients will probably be few, but you have a duty to face them honestly. Of course, to be sure your first impressions are correct, you should complete the evaluation before deciding. Then you might say something like this:

> "Quite frankly, I'm not sure I'm the right person to deal with your problem."

You'd go on to explain why you've come to this conclusion (leaving out the unflattering bits), then recommend where the patient might go next:

> "Yours is the sort of problem that I haven't had much experience with. However, I know someone in this same building who has made a study of people with your kind of difficulty. If you'd like, I can write a note that describes my findings in your case."

CHAPTER 4

Managing the Early Patient Interview

A few minutes into a typical initial interview session, the patient should be relaxed and giving you the information you need; much of your task right now will be simply to keep your patient talking. Most patients feel highly motivated to talk, and you will usually need only to choose the device that will best encourage them to do so. (If this isn't the case with your interview, you can review the material in Chapters 16 and 17 for help.)

To keep speech flowing freely, intrude as little as possible. Anything you say—questions, comments, even clearing your throat—can prove distracting. As long as you are finding out why your patient came for treatment, you should keep out of the way. In practical terms, you will usually just listen for only the first couple of minutes or so. Then the flow of information will slow down or take a wrong turn, and you will have to intervene. Your choice of interventions can help determine the overall success of your interview.

NONVERBAL ENCOURAGEMENTS

Your most frequent challenge may be dealing with silence. Beginners often find silence hard to tolerate. They feel that every hole in the conversation, no matter how small, must be filled up with words. It is true that pauses greater than 10 or 15 seconds can make an interviewer seem

cold, and this discourages some patients. Briefer pauses often mean only that your patient is trying to organize some thoughts for further discussion. Don't let anxiety cause you to derail a train of thought that has only paused to gather steam.

You must learn to walk the line between allowing brief pauses to let your patient think and long gaps that make you seem unfeeling or uninterested. A glance should tell you whether the narrative is still underway. Watch for the patient to draw another breath or to show other signs of activity, such as the moistening of lips.

You can encourage further speech by using nonverbal cues of your own. Be careful not to break eye contact; a smile or nod will say, "You're doing fine; just keep on going at your own pace." Another technique experienced interviewers sometimes use almost without thinking is to lean a little closer to show interest in what the patient is saying. Nonverbal cues of this sort are simple and often highly useful encouragements. Without interrupting, they clearly signal that you are attentive and interested; they are part of a universal body language that asks the patient to continue. But don't overemphasize any of these gestures: A clinician who nods too vigorously or smiles too broadly may distract the patient, who may then wonder what these antics mean.

VERBAL ENCOURAGEMENTS

Body language helps, but you will also have to do some talking. Your choice of words is important: You want to facilitate, not distract. Therefore, speak as briefly as you can while still conveying your meaning.

A syllable or two is usually all it takes. "Yes" or "Mm-hmm" clearly indicates that the material is registering with you. Without being directive, brief interjections and phrases ask the patient to keep on talking. Use them frequently, perhaps interspersing them randomly with nonverbal encouragements. One such encouragement every minute or two should help keep your patient talking.

There are several other verbal techniques you can use to request additional information. These are more intrusive than those just mentioned, so you should use them sparingly. I will illustrate each—some of them have been termed *reflective listening*—with a brief example.

- Repeat your patient's own last word or two with a rising inflection in your voice to make a question of it.

PATIENT: I was so upset that for hours I seemed to be hearing voices. *(Pauses.)*

INTERVIEWER: "Voices"?

PATIENT: In my head. I thought I heard the voice of my mother calling my name.

- Elaborate on a word the patient used earlier. This technique allows you to reach back to an idea that was not the last thought spoken.

PATIENT: I know I overreacted, but I was feeling desperate. I couldn't sleep or eat, and I screamed at my kids.

INTERVIEWER: You said you felt desperate. *(Pauses.)*

PATIENT: Yes, I even considered suicide.

- Directly request more information.

"Tell me more about that."

"How do you mean?"

- Re-request information when the patient seems to have misinterpreted your original question.

INTERVIEWER: What kind of work do you do?

PATIENT: It's at the foundry on Elm Street.

INTERVIEWER: And what kind of work do you do there?

- Offer brief summaries. These will often begin with "So you feel that . . ." or "Do you mean that . . ." Summaries not only help with transitions; they also offer concrete evidence that the patient has been understood.

INTERVIEWER: So for about 6 months now you've been feeling depressed and anxious.

PATIENT: That's right. Lately I've even started to think terrible thoughts—thoughts about killing myself.

Sometimes you'll get information you don't really want. It isn't that descriptions of recent vacations, children's witticisms, and arguments with lovers are uninteresting, but they can take up time you could better spend pursuing other issues. Although you might be able to discourage this sort of verbal wild-goose chase by simply not reinforcing it, it is often better to be direct with your patient:

"That's interesting, and maybe we can get back to it later, but right now I'd like to know about . . ."

Or perhaps to be even more direct:

"No, let's keep our focus on information that can help me help you."

OFFERING REASSURANCE

Reassurance is anything you do to increase a patient's sense of confidence or well-being. Because it shows that you like or are interested in the other person, it can also foster rapport. Used sparingly during the initial interview, supportive statements say, "I'm on your side. We'll get this job done."

Any interview can be therapeutic. Studies have shown that the mere act of sharing problems with another human being (even, in some cases, with a computer!) can help a person take a new view of old issues or put ideas together in novel ways. But with a new patient, you can't just jump in and start giving advice, making interpretations, or otherwise "doing therapy." Rather, the purpose of the initial interview is to obtain the information you need to plan treatment. On the other hand, you shouldn't pass up an opportunity to provide reassurance, as long as it doesn't interfere with the main goal of your interview. You might even raise the confidence of some patients enough that they will reveal especially sensitive material you would not otherwise have obtained.

Body language (smiles and nods) can be reassuring, but mostly you will reassure with speech. To be truly reassuring, what you say must be based in fact. You wouldn't get far saying, "You have a good head for finances," to a patient who in 45 years hasn't saved a nickel toward retirement. And choose your words carefully. Avoid clichés and other stereotyped expressions, which will make you sound as if you are responding only by rote, not from the heart.

In short, supportive reassurance must be factual, sincere, and specific to the situation. Here are two examples:

PATIENT: I did manage to get two promotions last year.

INTERVIEWER: So you've really done well with that job!

PATIENT: When he came at me with a knife, I jumped right through a second-story window onto a garage roof. It made me feel dumb. I thought I'd just saved him the work of cutting me to ribbons.

INTERVIEWER: It may have saved your life! Perhaps it was the only thing you could have done.

Avoid false generalizations that come too early in the interview or are based on too little factual information. "I'm sure it will all work out," or "Those fears seem groundless," will probably ring hollow to most patients, especially those with paranoia or severe depression; they *know* things won't turn out well! Even someone who is less severely ill might begin to question your knowledge if you leap in quickly with bland reassurances that cover too much ground to be believable.

Occasionally a patient will express concern based on a misconception about mental or physical phenomena. Then you can use your expertise to set the record straight without interfering with the history taking.

PATIENT: I'd never even been to California before, but I suddenly thought, "I've been on this same San Francisco street before." I wondered if I was losing my mind.

INTERVIEWER: That feeling is called *déjà vu*. It's very common, and doesn't mean anything at all is wrong. Now tell me what happened next.

Notice, however, that this interviewer did make the mistake of providing unconditional reassurance. Although *déjà vu* is nearly always a benign phenomenon, it is sometimes associated with neurological conditions such as temporal lobe epilepsy. But without more substantiating evidence, to suggest that there could be any pathological significance would also be a serious mistake. Here is a reasonable compromise: "It doesn't usually signify that anything is wrong."

Be careful to avoid offhand comments that may prove disquieting. One patient described a sexual encounter with her cousin, then said that she didn't know whether that would be considered molestation. "It sure sounds like molestation to me," responded the young interviewer. This response had the potential for raising anxieties that the patient was not ready to deal with. ("How do *you* regard it?" would have been a safer response.)

Mostly, your efforts at reassurance and encouragement will meet with success. Nevertheless, any of these techniques can sometimes backfire. A patient with persecutory delusions might interpret even a friendly nod or smile as mockery. If you lean toward someone who is feeling angry, you might be rewarded not with more information, but with hostility or deepening silence. Judging when a patient will not be receptive can be tricky. Your best bet is to start slowly. Be friendly and pleasant, but not aggressively so.

Watch for cues. If you are being too aggressively forward, your patient may exhibit some of these behaviors:

Loss of eye contact

Frozen expression

Decreased speech output

Nervous shifting of position

If you spot any of these telltale signs, quickly change to a more reserved manner.

CHAPTER 5

History of the Present Illness

Once you feel that there are no additional major problem areas to discover, close the period of free speech and move smoothly into the history of the present illness. (However, throughout the balance of your history taking, listen carefully for other clues that could suggest the need for further exploration.)

Now you will explore more thoroughly the problems that have brought the patient into treatment—the "meat" of the initial interview, including a description of symptoms, their timing, and possible stressors for each of the problems you've identified. To aid this process, you might consider the areas of clinical interest that you identified during free speech. These areas have been first mentioned in Chapter 2; because they include material from the MSE, they will not be considered fully until Chapter 13.

Although some patients have no diagnosable disorder, it is a convention to label as "illness" whatever brings anyone in for evaluation. In this broad sense, then, marital disagreements and other problems of living—even the desire to understand oneself better—may constitute a present "illness" that no one, least of all the patient, would recognize as disease. But all of these issues do have precipitants, symptoms, course, and other features that will allow you to suggest an effective plan of action.

THE PRESENT EPISODE

Although you will eventually want to learn about any and all episodes, first focus on the current episode of illness. Your patient will be most concerned about it, and its details will be freshest in the minds of all your informants. Of course, you'll need to know what symptoms you can expect to find in an episode of illness. For that, refer to textbooks and other

resources that cover this material (I've written one or two of these myself). Appendix D in this book presents a semistructured interview that covers the symptoms typically found in mental health patients. And Appendix B gives some very basic information about a few of the more common mental disorders clinicians commonly encounter. If your early interviewing experiences are anything like mine (see the very beginning of the Introduction to this book), you'll benefit by returning to your patient to ask the questions you've forgotten the first—or second—time around.

DESCRIBING SYMPTOMS

Learn as much as you can about each symptom your patient reports. (Remember that a *symptom* is any subjective sensation the patient reports. It doesn't even have to be unpleasant; pain, hallucinations, and anxiety are all symptoms, but so could be the ecstasy or feeling of strength in mania.) Clarify any descriptive terms that are used: For example, what does *nervous* mean to the patient?

Characterize each symptom as fully as you can. Is it always present, or does it come and go (is it *episodic*)? If episodic, as is the case with anxiety attacks and many depressions, how often does it occur? How intense is it? Is it always the same, or does it vary? Remember that symptoms can wax and wane with time or with changes in the environment. Has the patient noticed any factors (such as activity or time of day) that seem to be associated with the symptom? Has the intensity or frequency of the symptom been increasing, staying the same, or decreasing? When your patient has the symptom, how long does it last? In what context does it occur? (Only at night? Only when alone? Or at any time at all?)

How does the patient describe the symptom? Pain can feel cutting, burning, crushing, sharp, or dull. You can describe auditory hallucinations by their content (noises, mumbles, isolated words, complete sentences), location (inside the patient's head, in the air, out in the hall), and intensity (ranging from loud screams to faraway whispers). Other sorts of hallucinations—of vision, touch, smell, or taste—can be described similarly. I'll have more to say about this in Chapter 12.

VEGETATIVE SYMPTOMS

Many patients with serious problems such as anxiety attacks, depression, and psychosis have experienced *vegetative symptoms*. This old term refers to body functions that are concerned with maintaining health and vigor. Vegetative symptoms include problems with sleep, appetite, weight change, energy level, and sexual interest.

Not every patient will spontaneously report these symptoms, but they are found in so many of the more serious mental disorders that they serve as a useful diagnostic indicator. You should ask about them routinely. Look especially for evidence of *change* from previous normal functioning. You may find one or more of the following responses:

• *Sleep*. Your patient may complain of either excessive sleepiness (hypersomnia) or inability to sleep (insomnia). If the latter, find out what portion of the normal sleep period is affected—early (initial insomnia), middle (interval insomnia), or late (terminal insomnia). Terminal insomnia is usually associated with more severe mental problems, such as major depression with melancholia. Much more common is initial insomnia, which sometimes affects normal adults when they are having problems of living. Interval insomnia, in the form of awakening with nightmares, may be found in patients who drink alcohol heavily or who have posttraumatic stress disorder (PTSD). Here is how you might inquire about problems with sleep:

INTERVIEWER: Have you had any problems with your sleeping?

PATIENT: Yeah, it's been murder.

INTERVIEWER: What sort of trouble have you had?

PATIENT: What do you mean?

INTERVIEWER: Well, what part of the night do you not sleep well?

PATIENT: Oh. Mostly, it's trouble getting to sleep.

INTERVIEWER: Do you ever wake up early in the morning, before it's time to get up, and then you can't get back to sleep?

PATIENT: Yeah, that too. I do that a lot.

INTERVIEWER: How long do you usually sleep?

PATIENT: Lately, I guess . . . probably only 4 or 5 hours.

INTERVIEWER: And do you feel rested when you wake up?

PATIENT: Yeah, rested like I've been hauling bricks all night!

INTERVIEWER: How much of a change is this for you?

• *Appetite and weight*. These, too, may increase or decrease during an episode of illness. You should also learn how significant the change has been (how much weight has the patient gained or lost, and over what period of time?) Also ask whether this weight change was intentional. Some patients will tell you that they haven't weighed themselves recently; asking whether clothing has become too loose or too tight may help you judge.

- *Energy level*. Does the patient complain of feeling constantly tired? Is this a change from what's usual for this person? Has it interfered in some way with performance at work or school, or with getting jobs done around the house? You may also hear complaints of change in other body functions, such as bowel habits. For example, some severely depressed patients experience constipation.

- *Diurnal variation of mood*. This phrase refers to the tendency of some patients to feel better during a certain part of the day. Patients with severe depression often feel worse upon arising and better as the day goes on. By bedtime they may feel nearly normal. Those who are less depressed are more likely to report feeling better early in the day, but depressed, sluggish, and weary by nightfall.

- *Sexual interest and performance*. Sexual functioning usually depends strongly upon the individual's sense of well-being. Therefore, loss of interest in sex is often an early casualty of mental distress. Also learn how these aspects of the patient's sex life have changed: frequency, ability, and enjoyment. The direction of change could be either up or down, depending on the specific mental health problem. Number and choice of partners can also be affected if judgment is impaired. A more detailed description of sexual symptoms and patterns will be given in Chapter 9.

CONSEQUENCES OF ILLNESS

Mental disorder can interfere with the entire range of human interaction. For several reasons, it is important to learn how your patient's illness has affected functioning and relationships across all areas of functioning, including social, educational/occupational, and family life.

1. It may provide your most reliable index of severity. So far, most of the history you have heard is highly subjective: You depend on your patient's ability to sort out facts from opinions. Partly because it can be verified by talking with informants, the fact that a patient has not gone to work for a week may be subject to less distortion than, say, how much vodka this same person has consumed.

2. The definition of many disorders in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5)—the current iteration of the chief diagnostic manual used in the United States and abroad—depends heavily on social consequences: What have been the effects on the patient? On others? Substance use disorders and antisocial personality disorder are examples of conditions that can entail legal, financial,

health, and interpersonal problems. However, the criteria for most disorders require that you know the how symptoms affect functioning.

3. You may learn that relatives blame the patient for being fired, getting divorced, or separating from family members. Yet these and various other ruptured human relationships are really *effects* of the person's mental disorder. This view may prove useful to patient and relatives alike: Teaching family and friends about the consequences of illness can help get your patient off the hook.

To learn what social problems your patient's illness has caused, start with an open-ended question—one that doesn't limit the information you might obtain. If your patient asks what your question means, respond with some examples of the sort of facts that would interest you.

INTERVIEWER: What sort of difficulties has this problem caused you?

PATIENT: What do you mean, "difficulties"?

INTERVIEWER: For example, it would help to know whether your problem has changed the way you get along with your family and friends, how you do on the job, your hobbies—that sort of thing.

Be sure to obtain details about any positive answers. Areas to explore include the following:

• *Marital/couple.* Patients who are even moderately ill commonly experience discord in their marriages and other love relationships. All too often, mental disorder can lead to divorce or breakup.

• *Interpersonal.* Has your patient felt estranged from relatives or shunned by friends? Can you tell whether this is only a perceived problem, or has behavior been problematic long enough that others really do avoid the patient? Ask:

"Did anything you did cause problems for you or your friends or family?"

• *Legal.* Have there been legal difficulties? These are especially likely when the history is complicated by alcohol or other substance use. Ask:

"Have you ever had any police or legal difficulties?"

"Have you ever been arrested? How many times? What for?"

"Have you been in jail? For a total of how long?"

"Have you ever been committed to an institution or placed under the control of a conservator, guardian, or fiduciary?"

When such legal steps occur during a siege of mental disorder, they suggest serious illness. Be sure to obtain details: events leading up to the legal action; duration; name and responsibilities of the legally responsible person; and the effect the action has had upon the course of the disorder.

- *Occupational/educational*. As a result of emotional problems, has the patient ever missed work, quit a job, or been fired? How often has this happened? Difficulties with job performance are sometimes noted by supervisors or co-workers even before family members take much notice of the patient's difficulties. For younger patients, ask analogous questions concerning school attendance and performance.

- *Disability payments*. Have benefits been awarded from the Department of Veterans Affairs (VA), the Social Security Administration, a state compensation board, or private insurance? For what disorder? What percent is the disability rating? What is the dollar amount? How long will the payments last?

- *Interests*. Has the patient's interest in hobbies, reading, or watching TV changed? Has interest in sex either increased or decreased? What about sexual performance? Have there been complaints of impotence, painful intercourse, or inability to have climax? There's more about this in Chapter 9.

- *Symptoms*. How much discomfort do the symptoms cause? What fears does your patient have about the meanings of the symptoms? Do they seem to imply death or permanent disability? Insanity? This information will also help you evaluate depth of insight and soundness of judgment, which we'll discuss in Chapter 12.

ONSET AND SEQUENCE OF SYMPTOMS

In addition to a complete and accurate description of the symptoms, you should establish their timing and sequence. First, when did these problems begin? Some patients may report this quite precisely: "I started drinking again last New Year's Eve," or "I woke up feeling depressed a week ago Thursday." But more often the answer will be less exact, either because the patient is vague or because the episode began so gradually that neither the patient nor you can pinpoint the onset.

Try to encourage precision about the onset of especially noticeable symptoms. (Sometimes details are especially important, as in the case of a first panic attack or a horrific event precipitating PTSD.) Patients can often remember the first time they experienced such important problems as death wishes or loss of interest in sex. You might be able to relate onset to noteworthy dates or events.

INTERVIEWER: Had you started to feel depressed by the Fourth of July last year?

PATIENT: No, I don't think so.

INTERVIEWER: What about in the fall, around the time of your birthday?

No matter how much you prompt, some patients simply can't give a date or even an approximation: "I only know it's been a long time. A very long time." Pressing for a more precise answer will probably only frustrate both of you. Try focusing instead on something the patient may have thought about many times:

"When did you last feel well?"

If even this effort fails, at least try to learn which of your patient's several problems started first. It is often important for diagnosis and treatment to know, for example, whether an episode of depression or a bout of drinking began earlier. So ask:

"Which did you notice first, the drinking or the depression?"

"How long did it take before the other problem developed?"

If symptoms fluctuate, ask:

"Do they come and go together?"

STRESSORS

Of course, having mental symptoms is enormously stressful itself, but here let's consider stress in a different sense. A *stressor* is any condition or event that seems to cause, precipitate, or worsen a patient's mental health problems. Sometimes they are referred to as *precipitants*.

"My husband ran off with his secretary."

"I flunked out of school."

"My cat died."

The variety of possible stressors is vast, and what one person might find mildly stressful could seem catastrophic to someone else. For years (until the publication of DSM-5), the diagnostic manuals listed nine groups of potential psychosocial and environmental problems, comprising

many individual stressors. In Table 5.1, I have paraphrased many of these stressors; they should have occurred within the year prior to your evaluation. When you are listing them as part of your diagnostic evaluation (see Chapter 18), be as specific as possible.

Patients often mention stressors during free speech, or even when stating the chief complaint. If they don't, you will have to ask. A good time to do so is right after you have pinned down the approximate onset of the episode of illness. If you find a stressor, try to learn how it affected the course of your patient's difficulty. Ask:

> "Was anything happening then that might have started your symptoms?"
>
> "How did it affect you?"

If your patient can think of no possible stressor, you should run through a list of possibilities, pausing briefly to allow thinking time:

> "Could there have been anything that happened at home? At work? With friends? Any legal problems? Sickness? Problems with the kids? With your spouse?"

TABLE 5.1. Psychosocial and Environmental Problems

These stressors may have been caused by a mental disorder, or they may be independent events.

Access to health care services: inadequate insurance or health care services; lack of transportation to health care services

Economic: marked poverty; inadequate finances or welfare support

Educational: academic problems; arguments with classmates or teachers; illiteracy; inadequate school environment

Housing: homelessness; inadequate housing; dangerous neighborhood; arguments with landlord or neighbors

Legal system/crime: arrest; incarceration; litigation; being the victim of crime

Occupational: stressful work conditions or schedule; job change or dissatisfaction; arguments with supervisor or co-workers; retirement; unemployment; threatened job loss

Social environment: death or loss of friend; difficulty with acculturation; discrimination; living alone; social isolation

Support group: death or illness of relative; family disruption by divorce or separation; parent's remarriage; physical or sexual abuse; discord with relative

Other: arguments with nonfamily caregivers (counselor, social workers, physician); unavailable social service agencies; exposure to disasters, war, or other hostilities

For some episodes of illness you'll find no stressors at all, but to a patient almost anything can seem a possible cause of emotional disorder. Therefore, events reported as stressors may include births, deaths, marriages, divorces, job loss, a broken love affair, health problems, and virtually any other emotional trauma you can think of, as well as many life experiences that might seem routine.

Of course, your patient's identification of something as a stressor doesn't mean that it actually caused the disorder to happen. Often two events simply occur by coincidence, but we humans tend to blame any problem on whatever happened before it. For example, if you carefully checked the time course of Mrs. Albertson's depression, you might find that she had some symptoms—perhaps insomnia and some crying spells—even before her husband left her.

Another patient's "stressor" may seem an unlikely cause of illness, as in the case of the woman whose overwhelming depression started, she said, when she learned her niece was pregnant. Whether or not the stressor seems related to the disorder, note it down. You can evaluate it later in the light of everything else you learn about your patient.

Even though you might find nothing that could have precipitated the episode of mental illness, try to answer this question: Why has your patient appeared for evaluation now? In some cases, it will not have been the patient's choice, but someone else who perceived the need for help in the purchase of a gun, withdrawal from family life, or acute intoxication. If the answer isn't so obvious, the best approach is to ask:

"This problem has been bothering you for a long time. What made you seek help now?"

When the patient has come voluntarily for evaluation, you are likely to hear about the urging of concerned relatives, fear of losing a valued job, or the patient's own anxiety about worsening symptoms.

PREVIOUS EPISODES

Knowing about previous episodes of the same or a similar mental condition can help you determine diagnosis and prognosis. By this time you may already have heard details about any prior episodes. If not, ask:

"When was the first time you felt like this?"

"Did you first seek treatment then or later?"

"Why did you delay?"

"What was the diagnosis?" (There may have been more than one.)

Since that first episode, has there ever been complete recovery, or has the patient continued to have some residual symptoms or an apparent change of personality? This issue of complete recovery can be critically important. For example, it can help differentiate schizophrenia (from which most patients never totally recover) from a mood disorder with psychosis (which usually resolves completely).

How has your patient reacted to previous symptoms or prior episodes of illness? Some patients may have simply ignored them; others may have tried to escape by quitting work, running away from home, attempting suicide, or abusing alcohol or other drugs. People who experience auditory hallucinations sometimes play the radio loudly to drown out the sound. A few will have talked with a friend or a religious counselor. Whatever the coping behavior, this information may help you evaluate the severity of the present episode by comparing it with earlier episodes. It could also help you predict how your patient would behave if the illness continued untreated.

PREVIOUS TREATMENT

Has your patient received treatment before? If so, to guide your plans for future therapy, you'll want to obtain details about what was offered and what was tried.

If the patient had psychotherapy, what was its nature? Cognitive-behavioral therapy is popular nowadays, but there are many other possibilities. Was the therapy individual, group, or couple? Try to learn the name—certainly the profession—of the previous therapist. How long did treatment last? Why did it stop?

Were drugs prescribed? If so, which ones and at what doses? Were there any side effects to drug therapy? If your patient doesn't know the names of previous medications, a physical description of the tablets or capsules might give you or a pharmacist consultant some clues. A list of side effects might also help you with drug identification. Find out whether injectable medications were ever used, especially the long-acting injectable antipsychotics such as fluphenazine (Prolixin), haloperidol (Haldol), risperidone (Risperdal), olanzapine (Zyprexa), and paliperidone (Invega).

Also try to evaluate how well the patient complied with treatment. If you ask a straight question about this, pride or guilt may cause some patients to have trouble answering the question candidly. Try instead:

"Were you usually able to follow your therapist's directions?"

If the answer to that question is "No," ask:

"What sort of trouble did you have?"

What have been the effects of previous treatment—has anything helped? If so, try to get an opinion as to which treatment helped most (talking with a therapist? behavior therapy? electroconvulsive therapy? medications?). You could be surprised. Even though an antipsychotic might be the current medication, your patient might answer that lithium helped most, and request it again.

Was the patient ever hospitalized? If so, how many times? Where, and for how long? If time is short and your patient is both knowledgeable and cooperative, you might instead ask for a written summary of previous hospitalizations and treatment to be given to you at your next interview.

CHAPTER 6

Getting the Facts about the Present Illness

Of all portions of the initial mental health interview, the history of the present illness is probably the most important. (It is also frequently neglected.) Here is where you will develop most of the information and test the hypotheses that provide the basis for your diagnosis. This process requires obtaining highly *valid* information; that is, it should reflect as closely as possible the true facts of your patient's history. You can take several steps to increase the validity of the information you record in your history of the present illness.

BE CLEAR ABOUT THE GOALS OF YOUR INTERVIEW

Ideally, your patient will understand your expectations for accuracy from the very beginning. Still, in the middle of the interview, your apparently truthful patient may seem to be holding back on you. Something in the patient's manner may tell you—a hesitation of speech or an unwillingness to look you in the eye. Of course, your first task should be to try to understand any such behavior; we'll cover in detail the reasons for patient resistance in Chapter 16. For minor evasions and omissions, it may be enough simply to restate the goal of your interview:

> "I know some of these topics are hard to talk about, but to help you most, I need every scrap of information I can get."

If you are a student, you will have less authority to require cooperation, so you might try something like this:

"I'm sorry to be causing you distress with this line of questioning, but you've really been helping me with my studies. I know it's painful to talk about, but maybe getting in touch with some of these memories and feelings could even help you understand your problems."

It can be especially hard to obtain good-quality facts from teenagers. Some teens worry a lot about what you might tell their parents; others may mistrust anyone more than 5 years older than they are. Whatever the cause, some teenagers have trouble telling the truth. It sometimes helps to repeat your reassurances about confidentiality. I say something like this:

"As you'd expect, after we're finished I will have to talk with your parents. But anything I might tell them I will first discuss with you. And as long as I think you're safe, if you tell me anything that you don't want me to repeat, I'll respect that confidence."

Some jurisdictions allow you to counsel or treat teenagers for certain problems such as venereal disease and birth control, even without informing their parents, in the hopes of encouraging young people to consult appropriate caregivers about important health conditions. In such a case, you might work with your patient to determine the best way of informing the parent, but you shouldn't take it upon yourself to volunteer this information. If a teenager is brought in by a parent, then you would usually consult the parent—after informing your patient what you plan to say.

Information that isn't valid can be confusing, especially in the initial interview, so some clinicians begin interviews with teenagers by indicating that they prefer silence to misinformation. Here's how they might put it:

"A lot of the questions I am going to ask you are personal. Some of them may be pretty embarrassing or even frightening. But if I'm to help you, it's important that I not get confused by something that isn't the truth. So if you can't bear to discuss what I'm asking about, please don't make up an answer. Just say that you don't want to talk about that now, and we'll go on to something else. OK?"

TRACK YOUR DISTRACTIONS

Hardly any interviewer proceeds smoothly and logically, covering one topic completely before moving on to another. In fact, experienced interviewers expect to be distracted occasionally by—well, the unexpected.

When new material interrupts the flow of your interview, you can either pursue it immediately or, if you feel the original topic is more important, make a note to come back to it later. If you choose the latter course, you should acknowledge that your patient has said something important, and promise that you will return to it shortly.

PATIENT: Yesterday I felt so disgusted with myself that I got out my suitcase, just to see how it felt in my hand.

INTERVIEWER: You must have been feeling pretty bad, to think about leaving home. I'll ask you more about those thoughts in a few minutes, after we've finished talking about your drinking.

In clinical interviewing, you must constantly reconcile two opposing principles: harvesting all the necessary information while avoiding the bog of excessive detail. For example, you'd certainly want to know about the family uproar that occurred last month when your patient was becoming severely depressed, but not at the expense of uncovering enough symptoms of depression to make a solid diagnosis. Resolving this dilemma often means putting off until later questions that, however much you'd like their answers, must take a back seat to other, more burning issues. It's an ideal time to make some notes for future reference.

USE OPEN-ENDED QUESTIONS

Above all else, you want information that is valid. Studies have shown that patients give the most valid information when they are allowed to answer freely, in their own words, and as completely as they wish. For that, you need an open-ended question—one that cannot be answered "yes" or "no" or with a specific piece of information (such as someone's age, a location, a physical attribute). Whenever possible, phrase your question in an open-ended way that allows the widest possible scope of response. Here are some examples:

Instead of "Did you have insomnia when you were most depressed?" try "How was your sleep then?" (Your patient might have been sleeping too much, rather than too little.)

Instead of "How many times have you been hospitalized?" try "Tell me about your previous hospitalizations." (The details could reveal suicide attempts or bouts of drinking.)

Instead of "Did you lose your appetite?" try "To what extent did your appetite change?" (The phrase "to what extent" can change nearly any closed-ended question into one that is more open-ended.)

TALK THE PATIENT'S LANGUAGE

Even the most experienced interviewers must guard against using technical words that patients might not understand.

> "Has your libido remained healthy?" asked one professor of psychiatry (!) during ward rounds. The patient, a burly high school dropout, looked perplexed.

If you use an unfamiliar word and are asked to define it, you won't lose anything but a little time. However, some patients are reluctant to admit their ignorance, and so say nothing. Others sometimes think they understand when they don't. If they answer the question they *thought* you asked, the information you get might not be accurate.

You will improve validity if you pitch your questions at a level the patient can understand. Even then, you may find that your patient has a different understanding of a word whose meaning you thought was pretty well standardized. For example, some people will hear *anxious* and think "eager"; others may say *paranoid* to mean "fearful."

At the same time, be careful not to talk down to your patient.

> An interviewer asked one patient, a man with a master's degree in psychology, "How's your thinker?" The patient at first did not understand. When the clinician's meaning was finally explained, the patient felt so insulted that he left the room without finishing the interview.

Although most patients will not react so extremely, remember to approach all adults (and children, for that matter) with full regard for their intelligence and feelings.

In polite society, everyone uses circumlocutions at one time or another. For example, "sleeping with" is commonly used to mean "having sexual relations with"—any actual sleep is an afterthought. You should try to preserve amenities, of course, but your first obligation should be to communicate accurately. Asking whether your patient had "sex before getting married" is discreet but inaccurate; nearly everybody has, even if it's only masturbation. If you really need to know about a history of sexual intercourse, ask that question in so many words. In Chapter 9 we'll take up some methods to help you approach the sensitive subjects of sex, suicide, and substance use.

You should work hard to be sure that you understand what your patient is trying to say. For example, what does "I was off the wall" mean? To find out, you could do one of two things:

1. State your understanding of the expression: "You mean you felt very upset?"
2. Simply ask what was meant: "I don't understand how your statement relates to what we were talking about."

Ensuring good communication requires your constant vigilance. It is all too easy to assume that you know what your patient means, when in fact the two of you are speaking in different idioms.

In the same vein, be careful not to judge other people's behavior by your own. A common example is duration of sleep. You might suppose that your patient, who sleeps only 6 hours each night, suffers from insomnia, but for some people that's plenty (Thomas Edison slept only 4). Keep in mind that humans have an almost endless variety of preferences and habits, and guard against the temptation to impose your standards on others.

CHOOSE THE RIGHT PROBING QUESTIONS

When you want to know about something, just ask. A simple request for information will often produce what you need for a minimum effort. Your patient might appreciate your directness; if you use an open-ended question, you'll probably get the details.

When it comes time to delve more deeply into your patient's presenting problems, choose your probing questions with two principles in mind:

1. Select probes that will resolve unanswered questions. It's more efficient to concentrate your efforts on areas you haven't already covered.
2. If your questions show your familiarity with the illness, you will be perceived as knowledgeable. The resulting rapport and trust should lead to increased sharing of information.

At this point in your interview, you are interested in the facts, so questions that begin with "Why . . ." are often better avoided. This is especially true if the questions refer to the patient's opinions or to other people's behavior. Besides, "Why . . ." questions can prove frustrating to a patient who lacks insight, and this frustration can inhibit the formation of rapport.

"Why do you think you're having these symptoms now?"

"Why did your boss say that?"

"Why did your son leave home?"

Each of these questions invites speculation rather than facts. Later you may want to hear about possible interpretations, but at first you should try to avoid the opinions and concentrate on the data that will allow you to form your own conclusions. Try asking instead for more details or for some typical examples. (Fair warning: Later, I'll break my own rule and mention a couple of specific situations where you might use "Why . . ." questions to good effect.)

Getting a good history depends in part on knowing what questions will help you better understand the facts about your patient's symptoms or problems. Each symptom has its unique set of details that must be explored, but for a full, rich exploration of any behavior or event, certain items of information are always necessary. They include accurate details about these aspects of your patient's symptoms:

Type

Severity

Frequency

Duration

Context in which they occur

Because you will now be looking for specific details, you will be using more closed-ended questions—those that can be answered in a few words and *don't* invite further comment from your patient. Even when pursuing details, you should still sprinkle in some open-ended questions, which will stimulate your patient to relate additional material that you may not have thought to ask about. In the following example, the clinician uses a mixture of closed- and open-ended questions to explore a patient's anxiety attacks:

INTERVIEWER: When did you first notice these episodes of anxiety? [Closed-ended]

PATIENT: I guess it must have been about 2 months ago—I had just started my new job with the county.

INTERVIEWER: Would you describe an episode for me? [Open-ended]

PATIENT: It's pretty much the same every time. For no reason I start to feel nervous, and then I'm afraid I won't be able to breathe. It's awfully scary.

INTERVIEWER: How often have they occurred? [Closed-ended]

PATIENT: It's been getting more frequent. I'm not sure I can say.

INTERVIEWER: Well, has it been several times a day, once a day, once a week? [Closed-ended, multiple-choice]

PATIENT: About once or twice a day now, I'd say.

INTERVIEWER: What do you do about it? [Open-ended]

PATIENT: Usually I just sit down. I'm usually too shaky to stand, anyway. After about 15 minutes, it starts to go away.

INTERVIEWER: What sort of help have you sought before? [Open-ended]

Some rules of interviewing seem obvious, but they should be mentioned for the sake of completeness.

• *Don't phrase questions in the negative.* ("You haven't been drinking heavily, have you?") The effect is to telegraph an expected answer, which in this case would be "Heck, no."

• *Don't ask double (or, worse, multiple) questions.* ("Have you had trouble with your sleep or appetite?") Double questions may seem efficient, but they are often confusing. Without your realizing it, the patient may respond to one part of the question while ignoring another.

• *Avoid obvious pejorative questions.* ("Has your drinking ever caused a serious lapse of judgment?") Here, for no gain, you risk raising your patient's defenses. Better accepted might be a simple question about any problems the patient may have had from drinking.

• *Avoid leading questions.* ("Did your wife's leaving you cause you to start drinking?") A leading question is one that (often broadly) hints at the answer expected. Judges on TV crime shows overrule leading questions, and so should you. They represent the opposite of your quest for honest, open-ended inquiry. Instead try, "What was going on in your life before you started drinking?"

• *Encourage precision.* Where appropriate, ask for dates, times, and numbers. And ask your patient to define any use of vague words such as *seldom, sort of, occasionally, sometimes, many,* and *most.* (By the way, try to make your own language as precise as possible.)

• *Keep questions brief.* Long questions with much explanatory detail can confuse the patient; they also occupy time you could be using to obtain information.

• *Watch for new leads.* Even when you are hot on the trail of vital information, be alert for hints of other directions to explore later.

PATIENT: . . . That's about the story of my first suicide attempt. It really upset my mother, so bad she had a nervous breakdown. Now did you want to hear about the other attempt?

INTERVIEWER: (*Noting on pad, "Mother's breakdown."*) Yes, please.

CONFRONTATIONS

Of course, *confrontation* does not mean showing anger, much less coming to blows. In the context of a mental health interview, it simply means pointing out something that requires clarification. It could be an inconsistency between two points of the history, or between the story and how the patient appears to feel about it. The purpose of the confrontation is to help you and the patient communicate better.

INTERVIEWER: I've noticed that whenever I ask about your father, you glance away. Did you realize that?

PATIENT: No, I didn't.

INTERVIEWER: What do you suppose it means?

In the usual initial interview, you should try to avoid any confrontation that's more than the mild sort I've just illustrated. In the first visit or two, you don't know one another well at all; your patient could feel tricked or trapped by a relative stranger who points out inconsistencies. That could lead in turn to decreased cooperation with the history taking or, in extreme cases, to a breakdown in communications. But if you seem to be getting contradictory information on an important point, try to enhance validity by asking for clarification.

When you do ask, be gentle. The experience of being interrogated is an unpleasant one; it makes the subject feel attacked and defensive. If instead you coat your confrontation in warm empathy, it is less likely to be rejected. If the patient sees you as interested and concerned, the confrontation should lead to an increase in self-exploration.

You can also make the confrontation seem less like a challenge by choosing your phrases carefully. You might express puzzlement and ask for help:

"Here's something I don't understand. You just said that your husband drove you to the hospital, but I thought that earlier you told me he had run off with his secretary."

Notice the "I thought." It implies that you, the interviewer, might have been mistaken. The overall effect of the confrontation just quoted is to make you and the patient collaborators in the search for truth. In another example, to a patient who has made what seems to you an illogical (perhaps delusional) connection, you might simply probe, "I don't think I quite follow that."

Suppose you observe that your patient's appearance and thought content do not jibe. A confrontation asks for clarification:

"What you told me about your mother-in-law is sad, but you seem to be smiling. There must be something else to this story."

Whatever the issue, try to restrict your confrontations to one or two essential issues. Otherwise, you do put rapport with your new patient at risk. To be sure that you reserve this treatment for only the most important issues, it might be better to save any confrontation until near the end of the interview. Your relationship should be stronger by then (the risk will be lessened), and you will have already obtained most of your information (you'll have less to lose). Any risk you do take will be in the service of resolving an important issue.

CHAPTER 7

Interviewing about Feelings

Dates, events, and other facts provide only the bare bones of your patient's problems; they must be fleshed out with feelings and reactions to give the problems substance. Whatever the nature of the presenting problems—even in patients with psychosis—feelings about the illness, and indeed about the interview itself, will probably rank among the most important data you obtain during the entire interview. Yet studies have shown that of all the topics that must be covered in an initial mental health interview, the one most often ignored by beginning interviewers is feelings.

NEGATIVE AND POSITIVE FEELINGS

People can experience an impressive range of feelings. In listing a few of them (Table 7.1), I have tried to be comprehensive. Some are major moods or affects; others are variants or combinations. All are represented by commonly used words. Although in nearly every case a noun form exists, I have listed adjectives (with some synonyms and related words), because that is how people express these ideas in reference to themselves. For example, we are more likely to say, "I feel [am] anxious" than "I have anxiety."

In most cases I have paired feelings with their opposites. (Note that the negative feelings considerably outnumber the positive ones.) I have omitted most of the obvious antonyms (*un-* and *in-* words) and have omitted some words that are too vague to be useful as descriptors, such as *bad, good, nervous*, and *uncomfortable*. Because I wanted to include only those terms that are used to describe how people feel, in some cases I

TABLE 7.1. Negative and Positive Feelings

Negative feelings	Positive feelings
Afraid, fearful, apprehensive	Confident
Angry	
Anxious	Contented, calm, peaceful
Apathetic, indifferent, aloof, detached	Eager, enthusiastic, interested, enchanted
Ashamed, humiliated	Proud
Confused, perplexed, puzzled	Certain, sure
Disappointed	Fulfilled
Disgusted	Delighted
Dissatisfied	Satisfied
Embarrassed	
Envious, jealous	
Foolish	Wise
Frustrated	Encouraged
Guilty	
Hateful	Affectionate, loving
Helpless, dependent	Independent
Hopeless, trapped	Hopeful
Horrified	
Impatient	Patient
Indignant	Pleased
Inferior	Important, superior
Lonely	Sociable
Pessimistic	Optimistic
Regretful	
Rejected	Accepted
Resentful	
Sad, gloomy, depressed	Cheerful, happy, euphoric
Shy, timid	Confident
Surprised, astonished, amazed	Prepared
Suspicious	Trusting
Tense	Relaxed
Uncertain	Determined
Ungrateful	Appreciative, grateful
Unsympathetic, callous	Sympathetic, compassionate
Useless, worthless	Useful, worthy
Vulnerable	Secure
Wary	Trusting
Worried	Carefree

Note. Some terms, such as *wary* and *trusting*, could be considered positive or negative, depending on context. I've tried to compose this list according to the more prevalent meaning.

have listed no antonym. Thus *innocent* isn't given as an antonym for *guilty*, because people don't usually state that they feel innocent—"I am innocent" proclaims conviction, not emotion.

Of course, you can obtain information about feelings from most normally expressive people just by careful watching and listening. But some patients are reluctant to share their feelings; even when they are willing to talk, they bury their emotions deeply. Then you will have to go prospecting to uncover feelings.

ELICITING FEELINGS

Many patients—perhaps most—will express their feelings adequately if you just ask. Patients don't seem to mind this method. In fact, studies show that this direct approach is preferred by most patients and informants, as long as the interviewer has a warm and caring manner and is attentive, courteous, and responsive to cues.

Successful examiners effectively use two techniques that are especially good at eliciting emotions. These are the already-mentioned direct requests and open-ended questions.

Direct Requests for Feelings

Watch for the opportunity to ask about the feelings associated with any of the facts you have been discussing. Simply asking is probably the most effective method of eliciting emotions, but be careful to use the word *feelings* or a synonym. If you slip and say, for example, "What do you *think*?" you risk harvesting instead a lot of factual and cognitive material, especially if your patient is highly educated or otherwise tends to intellectualize. Here are a couple of examples of useful requests for feelings:

> "How did you feel when you found out that you would have to move?"
>
> "What was your state of mind when you were served with that subpoena?"

Patients are used to answering questions and will usually give you information about nearly any emotional state that you seem interested enough to ask about.

Open-Ended Questions

Without specifically asking how the patient feels, open-ended questions encourage the free expression of emotions. This method works because

its relative freedom encourages patients to speak at length. The more people talk, the more likely they are to reveal emotion-laden information.

This technique, which is really just an extension of free speech, works in part by suggesting that you care about how the patient perceives the situation as a whole. On the other hand, closed-ended, short-answer questions may suggest that you have already decided what is significant, reducing your patient's motivation to tell the entire story. Furthermore, it seems obvious that the less time you spend asking questions, the more time your patient will have to reveal feelings.

Open-ended questions can also help patients who have trouble sorting out or accepting emotions that conflict with one another. To describe conflicting emotions, we often use the term *ambivalence*; most people find it hard to express ambivalent feelings in just a few words. But a comparatively long run of uninterrupted talk may provide the time necessary for the patient to think about and express such feelings. Here's an example of an open-ended question that revealed decidedly mixed feelings:

INTERVIEWER: A few minutes ago, you said that your wife was talking about divorce. Could you tell me more about that?

PATIENT: It's been an awful time for me . . . I know that . . . well, I've always felt that if you've failed in your marriage, you've failed in life. At least, that's what my mother always said.

INTERVIEWER: *(Nods encouragement.)*

PATIENT: But when I think about it . . . you know, there's so much trouble we've had getting along, almost since . . . well, since the kids were born. Maybe we haven't really had much of a marriage at all. Maybe there are some things worse than divorce.

OTHER TECHNIQUES

Several situations can make it hard to elicit emotions from patients. Here are a few of them:

- From childhood, some people—especially males—are discouraged from revealing their feelings or displaying emotions. When they are grown up, this "macho" view of appropriate behavior can lead them to deny their feelings. The most obvious example is when the childhood admonition "Boys don't cry" becomes "Men should show that they don't care." The same fate can befall women, too.

- Some patients don't recognize their own feelings or have difficulty connecting their feelings to their experiences. Perhaps this, too, develops

from childhood experiences. In extreme cases, people grow up unable to recognize or describe how they feel—a condition called *alexithymia*.

- Still others may be reluctant to express themselves, especially to someone they don't know well, because it makes them feel vulnerable. "Show a hard exterior, and no one can hurt you" is how they might put it. In contrast to those with alexithymia, these people know how they feel and could put their emotions into words, but the need for self-protection wins out.

To elicit feelings in these situations may require you to use one of the techniques mentioned just below.

Expressions of Concern or Sympathy

Controlled studies have shown that any expression of concern or sympathy by a clinician may encourage a patient to share feelings. This is especially likely to work if your patient has already begun to share some feelings. The sympathetic expression you use can be either verbal or behavioral, such as facial expressions or other body language.

PATIENT: I've worked for that company for 15 years, but when a supervisory position opens up, the boss passes me over for his own nephew. It really burns me!

INTERVIEWER: *(Frowns sympathetically.)* It makes me feel unhappy just hearing about it! I think that anyone in that situation would feel hurt and angry.

PATIENT: I was beyond that—I was totally blown away. I wanted to flush myself out of existence! I still feel that way, sometimes.

Reflection of Feelings

Reflection of feelings means explicitly stating the emotion you think the patient might have felt in a given situation.

PATIENT: My daughter has always been a little wild, but last night she didn't come home until nearly daybreak.

INTERVIEWER: I'll bet you were nearly frantic.

Of course, this technique runs the risk that your interpretation could be wrong. But if it is, and your patient says so, you have at least accomplished your goal of promoting a discussion of feelings.

Picking Up on Emotional Cues

Picking up on emotional cues means being constantly alert for indications of high emotional concern. Often these will be nonverbal cues: a slight frown, moistening of the eyes, or any other idiom of body language. Your response might be verbal:

> "I thought you looked a little sad when you were talking about your mother. What were you feeling?"

You might also indicate your interest and support with some quiet action of your own, such as passing a box of facial tissues to someone who has begun to cry.

Interpretation

With interpretation, you draw parallels between the emotional content of current and past situations.

> PATIENT: My husband never listens to my opinion on things.
>
> INTERVIEWER: From what you told me before, it sounds like the way your father treated you when you were a teenager.

The technique of interpretation can be tricky to use. The patient must be receptive to explanations for behavior; ideally, the patient should be the one who suggests the connection. If not, offer the interpretation tentatively: It may be briskly rejected. Generally, I'd tend to stay away from interpretations during the initial interview; they are a device best used in later therapy by experienced clinicians.

Studies show that each of the techniques above can encourage a reticent patient or informant to offer up more emotions and to examine them at greater depth. However, none of them will discourage a normally expressive person from revealing emotions. They also require less in the way of detailed, extensive probing than do techniques that are less responsive to the needs of patients.

"Name the Feeling"

Just ask about the emotion you think your patient might be having:

> "Are you feeling depressed?"
>
> "Have you felt guilt [or regret] about [whatever situation you've been discussing]?"

Because it is closed-ended, reserve this technique for those situations where you have already tried to elicit feelings with more open-ended questions.

Analogy

Finally, for the patient who absolutely cannot identify the feelings that accompany a given situation, you could ask about times when similar feelings might have been experienced.

"Did you feel anything like this when your mother died?"

"Did you feel this way that time your boss used you as a bad example in front of the entire staff?"

FOLLOWING UP FOR DETAILS

Once you have uncovered some feelings, increase the depth of the interview by asking for more. Probe to elicit examples and to evaluate details.

INTERVIEWER: I'd like to hear some more about those rage attacks. When do you feel that way?

PATIENT: For one thing, it's whenever we go to visit my father-in-law.

INTERVIEWER: Have you had some previous unpleasant experiences with him?

PATIENT: I'll say! He almost ruined my marriage with some of his sly cracks.

INTERVIEWER: I'd like to hear an example of how you felt then.

Be sure to ask follow-up probing questions whenever your patient gives you the opportunity. Beginners sometimes uncover evidence of significant events or pathology, only to ignore it in the subsequent dialogue. Here is an unfortunate example:

INTERVIEWER: Were you ever approached for sex in any way when you were a child?

PATIENT: Well, yes, I was.

INTERVIEWER: *(Writes down "Yes.")* Where are you employed now?

Perhaps this interviewer felt uncomfortable at pressing ahead for the details, but the patient was left to deal with the frustration of pent-up information. Positive information should be followed up until you have learned who, what, when, where, why, and how.

DEFENSE MECHANISMS

When following up, you should also learn what your patient does to cope with feelings. These strategies for dealing with emotions and behaviors are called *defense mechanisms*. They may seem almost endless in their number and variety; consult standard texts for a more exhaustive listing. Following are some of the more common ones. Rather than just stating definitions, I will try to clarify what the terms mean with examples of defense mechanisms that might be used by an aspiring politician who feels anxiety and anger about losing a city council election.

Potentially Harmful Defense Mechanisms

In the potentially harmful group, I've included those defense mechanisms that generally allow a person to avoid confronting the effects of feelings or emotions. When stressed, most of us will occasionally be tempted to use one of these to shore up our egos.

Acting out. [The politician smashes the camera of a news photographer who is trying to take a picture.]

Denial. "The recount will show that I actually won."

Devaluation. "It's a lousy job anyway—the hours are murder, and you get nothing but complaints from the taxpayers."

Displacement. [The politician goes home and kicks the cat.]

Dissociation. [The politician awakens one morning in strange surroundings, unable to recall any events of the past 3 days.]

Fantasy. "Next year I'll run for Congress—and win!"

Intellectualization. "I view this experience only as an example of 'democracy in action.' "

Projection. [Unconscious thought: "I'd like to kill him."] "He's plotting to kill me."

Reaction formation. [Thought: "He's a miserable low-life."] "I'm proud to support the honorable council member."

Repression. [The politician "forgets" to attend a banquet in honor of the victor.]

Somatization. [The politician develops persistent chest pain of unexplained origin.] " . . . so I couldn't have served anyway."

Splitting. "Some politicians are good, some bad; my opponent's one of the bad ones."

Effective Defense Mechanisms

Better-integrated adults rely principally on some of the more mature defense mechanisms.

Altruism. "I'll support him; he has better qualifications than I do."

Anticipation. [Before voting begins:] "Of course, I could lose. But I've got other irons in the fire."

Humor. "In the campaign I said he was honorable; he said I was a jerk. Perhaps we were both wrong."

Sublimation. "I'll write a book about the campaign."

Suppression. "I'll put it to the back of my mind, and concentrate on the business at hand." [Note the difference—conscious intent—from repression, above.]

HANDLING EXCESSIVELY EMOTIONAL PATIENTS

Although you will usually want to encourage the expression of emotions, some patients are so emotional that it impedes their communication with other people, including therapists. People can experience excessive emotionality for a variety of reasons.

- They may be people who are angry, sometimes without knowing why.
- Others, such as those with some personality disorders, have learned that high-volume emotions help them get their way. Drama becomes a way of life.
- Even some people who don't have such severe underlying psychopathology may use high emotional output to control their families or friends.
- Some people have been reared in families where feelings are expressed loudly and often. By their imitation of others, this behavior becomes habitual.
- Anxiety causes some to behave this way.
- A few cannot stand the loneliness of silence.
- Perhaps your patient, recalling experiences with other clinicians, fears that you won't be interested or that there won't be enough time to tell the whole story.

Whatever the cause, excessive emotionality can focus too much of your attention on feelings, leaving insufficient time for gathering facts. In such a situation, try to adopt a brisk, controlling manner in which you

firmly direct the course of the interview. Several techniques can help you accomplish this objective.

1. Acknowledge the emotion. You may be able to turn down the heat by just putting a label on the emotion. Then the patient, seeing that you recognize the feeling, will no longer need to attract your attention to it.

> PATIENT: *(Shouting)* She's not going to jerk me around that way, not ever again!
>
> INTERVIEWER: You really feel angry. Frustrated and angry.
>
> PATIENT: *(More quietly)* Well, sure. Who wouldn't be? Wait'll you hear what she did last week.

This technique shows that you understand and accept how your patient feels, so it is probably the best one to use. Try it first.

2. Talk quietly. If your patient shouts, try lowering your own voice. Most people have trouble maintaining high-volume output when you are speaking so softly that you can barely be heard.

3. Explain again what information you are trying to get:

> "What I really want at this point is to learn about your family history. Perhaps later we can talk some more about your husband's girlfriend."

4. Redirect any of the patient's questions or comments that change the topic.

> INTERVIEWER: Now I'd like to hear about your son. You said that he was living with his mother?
>
> PATIENT: That's right, and she hasn't let me even talk to him on the phone for the past 3 months. Don't you think I should get a court order?
>
> INTERVIEWER: We might be able to talk about that later. Right now, I really need to know about your relationship with your son. Have you been close?

5. Switch to a closed-ended style. This style will indicate what sort of specific answer you would like to hear, as well as discourage further comment by the patient.

> INTERVIEWER: Could you tell me about your first marriage?
>
> PATIENT: It was a disaster! I've never forgiven that man! He was a complete brute! One time I cried for a month without stopping. Why, I couldn't even—

INTERVIEWER: *(Interrupts, recognizing that open-ended questions aren't useful.)* Was he a drinker?

PATIENT: Oh gosh, yes, he drank like a camel. He—

INTERVIEWER: *(Interrupts.)* How long did the marriage last?

PATIENT: Until I was 26, about 4 years. He was never—

INTERVIEWER: Was the divorce your idea, or his?

This interviewer was prepared to go on interrupting until the patient learned to stick to the main topic.

6. If you are still having trouble, check to be sure that the patient understands what you want. Here is how you might phrase this confrontation:

> "We seem to be having some trouble here with our communication. Have I made it clear what I need to know?"

Like other helpful confrontations, this one was expressed so as not to lay the blame entirely on the patient.

The aim of all these techniques is to reduce the patient's scope for excessive verbal and behavioral output. They should help you obtain the diagnostic information you need without sacrificing rapport. Occasionally, however, even these techniques are insufficient. If an outpouring of tears or other feelings prevents you from obtaining the information you need from a hospitalized patient, you may have to break off the interview long enough for the patient to get a better grip. Say something like this:

> "I can see you're too upset to continue today. Let's take a rest for now. I'll stop back and see you again in the morning, when you've had some sleep."

CHAPTER 8

Personal and Social History

Health care professionals don't treat illnesses; they treat people. You therefore need to know the context in which your patient's complaints have occurred. This requires learning all you can about family background and other aspects of biography. The process not only will help you get to know your patient, but may reveal material that illuminates and extends your knowledge of the cause and context of mental disorder. Some of it may have a direct bearing on the cause of an illness or on its treatment. Your patient has spent a lifetime accumulating these experiences, so there is almost no limit to the amount and variety of available information. What you learn will be determined by the purpose of your interview and the time you can devote to it.

While you are gathering biographical information, maintain a healthy skepticism about its validity. Human memory is fallible, especially when the human has an intense personal interest in what is being remembered. Accurate recall is more likely for major historical events such as births, deaths, and marriages, and for recent events that constitute the history of the present illness.

On the other hand, some material is especially subject to distortion: early childhood events, interpersonal disputes, everything reported secondhand, and any other item that requires interpretation. You should be constantly evaluating the validity of all interview data against your own internal standards ("Does this story seem likely? Does it even seem possible?"). Whenever possible, you should check accuracy with external sources, such as previous medical records and interviews with relatives and friends (see Chapter 15).

By the way, I fully realize that you're not going to collect all of these data in a single interview; augmentation later is a clinical fact of life.

In this and subsequent chapters, I will use *italics* to point out some possible interpretations of the material as we discuss it.

CHILDHOOD AND ADOLESCENCE

Family of Origin

A logical starting place is with your patient's birth. In what city/state/country did it occur? Was the patient an only child? If there were brothers and sisters, how many were there of each? What was your patient's position in the sibship (first, second, middle, youngest, or only child)? How well did your patient get along with siblings? Was one sibling favored over the others? *Older children in a sibship tend to receive more attention when they are young, whereas middle children may be relatively neglected; youngest children may be babied or spoiled. Genetic disorders that are obvious at birth or shortly afterwards (such as Down's syndrome) tend to occur late in a sibship.*

If your patient was one of twins, were they identical (one-egg) or fraternal (two-egg) twins? *Identical twins have inherited the same genetic material; fraternal twins are no more genetically alike than nontwin siblings. Some mental disorders, including schizophrenia and bipolar disorders, are much more likely if your patient is the identical twin of someone who has such a disorder.*

Did your patient feel wanted as a child? How close was the relationship with the parents? Did this change with adolescence? Was the patient reared by both parents? If not, was this due to death? Divorce? Military service? Prison? *Absence of a parent (especially the father) has been associated with antisocial personality disorder. In some studies, early death of a parent correlates with adult-onset depression.*

Occasionally a patient will tell you, "I never knew my father." You should gently try to learn whether the parents were ever married. (Using "Is it possible that . . ." can soften this question considerably.) *Even in our more accepting era, being born "out of wedlock" is a lifelong source of discomfort and embarrassment for some people.*

Whatever the exact nature of your patient's family of origin, you should try to learn something about how the parents (or surrogates) related to one another. Did they communicate well with one another? Show affection? Did they quarrel often? Fight? Did one physically abuse the other? How did their relationship affect the emotional climate in the home while your patient was growing up? *People often model their adult relationships on what they observed as the "norm" during childhood. On the other hand, some people go to extremes to be different from a parent whose behavior was perceived as undesirable or unattractive.*

If your patient was adopted, at what age did this take place? Can you learn anything about the biological parents or about the circumstances leading to adoption? Was the adoption intrafamilial (that is, the adoptive parents were blood relatives of the patient) or extrafamilial? *Many adopted people, especially adolescents and young adults, feel incomplete because they don't know their biological parents. This can result in a quest for roots that drives some*

adoptees to extraordinary lengths to discover (and in some cases meet) the birth parents who gave them up.

Growing Up

What was the age of each parent when your patient was born? Were the parents mature enough to provide responsible care? Did both work regularly outside the home? What were their jobs? Were they good providers? Did they have enough time left over to spend with children? What sort of disciplinary techniques were used? Were these harsh, firm, relaxed, or inconsistent?

If either parent was absent from home for an extended period of time, find out why. (Illness? A job far from home? Jail? Was your patient a "military brat"?) Did the family live in one place, or were there frequent moves? Did the family ever really put down roots somewhere?

Were there other losses, such as the death of a sibling, grandparent, or other close relative?

Find out about hobbies, clubs, and other extracurricular interests. Was your patient sociable? A loner? *Many people with schizophrenia have been isolated or loners for most of their lives.*

Try to obtain a general picture of the childhood environment and your patient's place in it. Here are some questions that might help you with this broad task:

"Could you tell me something about your childhood?"

"What was life like for you then?"

"How did you get along with your sibling(s)?"

"Who were your childhood friends?"

"Did you feel different from other kids?"

"How did you spend your free time?"

"Did you belong to organizations such as the Scouts or the Y?"

"Did you participate in organized sports?"

"Where did your family go on vacations?"

"Did your family have pets?"

"What chores or other responsibilities did you have?"

"What summer or after-school jobs did you have?"

"What did you want to be when you grew up?"

"With whom did you identify?"

"Was sex discussed in the home?"

"What were your parents' attitudes toward sex?"

"When did you first become interested in having a romantic relationship?"

Asking about Abuse

Many patients were physically abused as children—an experience that can significantly affect adult life and personality. This information can be difficult to obtain; sometimes these patients do not themselves realize the extent to which they were abused as children. You should nonetheless make an effort to learn whether your patient's childhood involved such experiences. You can lead into these sensitive topics gradually:

"How well do you feel your parents provided for you?"

"What methods of discipline did your parents use?"

"Did you ever feel that you were mistreated as a child?"

Positive replies to questions about abuse must be pursued thoroughly, if carefully. You will need to develop the following areas of information:

How often did this abuse occur?

Who administered it? Did both parents participate?

If one of them tried to shield the child, who was it?

What form did the abuse take? (Beatings? If so, what with?)

How often did it occur?

What was the provocation, if any?

At the time, did the patient feel that this abuse was deserved? What about now?

What effect did these experiences have on the patient as a child?

As an adult, how does the patient feel about these experiences now?

You'll need to ask about sexual abuse, too; we'll cover that issue in Chapter 9.

Childhood Health

For adult patients, early developmental milestones (such as the ages at which a child learns to sit, stand, walk, speak words, and speak sentences) are usually not worth pursuing. Most of what your patient knows about

milestones has probably been passed along as family mythology, which is highly subject to distortion. (Who remembers being breast-fed or toilet-trained?) But if you suspect intellectual disability or other developmental difficulties (such as a specific learning disorder), these milestones may be important enough to pursue with an informant.

Try to learn something about overall childhood health. Were there hospitalizations, operations, frequent visits to doctors, or long absences from school for health reasons? How did the family deal with illness? (Overprotection? Rejection?) If your patient was a sickly child, did the parents and other relatives "reward" illness behavior with a great deal of attention? *Overprotection or rewards for illness may precede what DSM-5 now calls somatic symptom and related disorders (the DSM-IV somatoform disorders).*

What was your patient's temperament and activity level, especially around ages 5–10? Was this child quiet and withdrawn, or outgoing and friendly? *Temperament characteristics appear in the first few months of life and tend to persist throughout childhood, even into the adult years. They may correlate with adult mental disorders.*

Does your patient report any of these relatively common childhood problems?

Bedwetting

Tics

Stuttering

Obesity

Nightmares

Phobias

If so, what treatment (if any) was attempted? Did it help? How did these problems affect relations with siblings or schoolmates? *Any of these conditions suggests that the patient was under stress as a child. Due to its increasing frequency, obesity may in recent years have become somewhat more accepted, but it still suggests a potential source of childhood hazing.*

Were there any concerns about masturbation? At what age did puberty begin? If your patient is female, was she prepared for the onset of menses? If so, who told her? At what age did they begin? Was she concerned or teased about breast development? *Teens of either sex can be exquisitely sensitive about being noticed. Developmental delay (or acceleration) may have caused your patient some degree of embarrassment.*

When did dating begin? What feelings were associated with this? Again, sexual history will be covered in Chapter 9.

Education

How well did your patient do academically, and what was the last grade completed? Did your patient like school? If there were academic problems, what subjects caused the most trouble? Were there any specific problems with reading (dyslexia)? With other subjects? Were there behavior problems in school? Truancy? What were the consequences? (Sent to principal? Paddling? Suspension or expulsion?)

Did your patient repeat grades or have difficulty concentrating on schoolwork? *Short attention span and low school performance suggest attention-deficit/hyperactivity disorder. Some of these patients (boys, especially) were markedly hyperactive as children, and may even have learned to walk early.*

Did your patient ever miss school for long periods of time? If so, why? Was there any history of school refusal? How old was your patient when it occurred? *School refusal (once erroneously called "school phobia") is fairly common in young children and does not necessarily predict later pathology.*

If your patient quit before graduating from high school, what was the reason? What did your patient do then? Work? Join the military? You should also learn whether a GED was attempted or attained. (These initials can stand for General Equivalency Degree [or Diploma] or General Educational Development.)

Finally, at what age did your patient make the transition from a life of dependency on parents or others to one of self-sufficiency?

LIFE AS AN ADULT

Work History

Employment history can help you judge both your patient's underlying potential and the effect of recent illness on performance. This information is also relatively objective: Work history seems to be distorted less than more personal, perhaps more embarrassing portions of the social history. You should therefore spend some time inquiring into the details of your patient's job history.

What is your patient's current occupation? Is it stimulating, satisfying? How does it match earlier ambitions? How long has your patient worked for the current employer? If the patient was ever unemployed, why and for how long? If the patient has been employed only briefly, how many jobs have there been in the last 5 years? Has each job change been for a better one? How much time is spent working? Investigate any gap, change of direction, or lack of promotion.

If your patient was ever fired from a job, what were the circumstances? If the patient is unemployed now, why? When did your patient last work

regularly? If the patient is unemployed, what is the current means of support? *Patients with antisocial personality disorder have often held multiple jobs of brief duration. No job at all, or none for many years, is commonplace among patients with chronic schizophrenia.*

While you are at it, find out about adult leisure activities. Does your patient have any hobbies? Belong to any clubs or other organizations? Have there been efforts at continuing education as an adult? What about talents? To learn more, you can ask:

"What do you think you're good at?"

Military History

Has your patient served in the armed forces? (Ask this question of both male and female patients.) If the answer is "Yes," ask:

"What branch?"

"Was this a volunteer enlistment, or were you drafted?"

"How long did you serve?"

"What was your job in the military?"

"What was the highest rank you attained?"

"Did you have any disciplinary problems?" (These include courts-martial, Articles 15, captain's masts, and lower-grade disciplinary hearings.)

"What kind of discharge did you receive?" (Honorable? General? Dishonorable? Medical?)

"Did you see combat? If so, for how long? What was your role?"

"Were you ever wounded?"

"Do you have a service-connected disability?" (This could be due either to wounds or to a non-combat-related accident or illness.)

"Were you a prisoner of war?"

"Do you tend to relive your experiences or have bad dreams or anniversary reactions?"

Symptoms that persist or recur after combat (or any severe service-related trauma) can indicate PTSD. This condition has been reported in 10% or more of Vietnam-era combat veterans, and it is turning up in large numbers among returnees from Iraq and Afghanistan. It may also occur after civilian calamities, such as car wrecks and natural disasters.

Legal History

Ask about any legal problems. These might include lawsuits over insurance or disability (especially likely in the case of a chronic illness, injury, or pain), evictions, and feuds with neighbors. In these litigious times, nearly any sort of dispute seems possible. *Legal history can serve as a clue to personality disorder, as well as illnesses such as bipolar disorders and substance misuse.*

Has your patient ever been arrested? If so, at what age? What were the circumstances? How many times did this occur? What was the outcome? (Conviction? Probation? Time in prison?) Was this in local confinement or in a penitentiary? What was the total duration of time served?

Has there been a continuing pattern of illegal behavior from adolescence throughout adult life? If so, have these criminal activities always taken place in the context of substance use, or have they also occurred when the patient was clean and sober? Have there been other illegal activities for which your patient has never been caught? It may be worthwhile to ask specifically about shoplifting, which is a relatively common behavior, especially in children and young adults. *In antisocial personality disorder, there is a continuing pattern of illegal acts from at least the teen years (and often much earlier). Partly because it carries such a poor prognosis, antisocial personality disorder is a diagnosis you should not make in any patient whose illegal behavior has occurred entirely while under the influence of drugs or alcohol.*

Religion

To what religion (if any) does your patient belong? Is this different from any religious affiliation of childhood? How often does your patient attend services? How does religion (or spirituality) inform your patient's life? *For several reasons, clinicians increasingly seek to explore patients' spirituality and belief in a supreme being. It can provide clues to possible sources of support and comfort, and may reveal something of your patient's values and system of ethics. It may also suggest the degree to which there has been a break with parents, and the possible presence of support from a community outside the nuclear family. On a practical level, just showing an interest in something the patient values can enhance rapport.*

Current Living Situation

Where does your patient live now? (House? Apartment? Mobile home? Rented room? Board and care facility? On the street?) What is the neighborhood like?

Does your patient live alone or with someone? If the latter, with whom? How well does your patient provide self-care? If there has been wandering, you might not learn details from the patient; this is material for which you may have to depend on informants. *Wandering is commonly found in patients with neurocognitive disorders.*

From what your patient says, can you characterize the quality of the home? Does each person who lives there have adequate privacy? Are there pets? Are there sufficient means of communication, including telephone, postal service, e-mail? What means of transportation does your patient use—car? bus? train? foot?

Has your patient ever been homeless? If so, for how long? What were the circumstances?

What is your patient's financial situation? What is the source of income? Is it steady? Be sure to include jobs, disability compensation, Social Security, annuities, alimony, and investments. Ask:

"Has money been a problem for you?"

Social Network

You can begin to assess the quality of social relationships by asking:

"To whom do you feel close in your family?"

"Who are your best friends?"

"How often do you see these people?"

If your patient is responsible for providing care for another adult, such as a parent, other relative, or friend, try to elicit feelings about these duties. Can you tell how well this function is carried out?

How much social support does your patient have? Are there personal contacts, or is support received principally through electronic social networks? Try to find out about the quality of relationships with family, friends, and co-workers. Are there memberships in any clubs or support groups? Have any government or private agencies helped out? What about home food services like Meals on Wheels? If there are grown children, how close is their relationship with the patient?

Does the patient pursue leisure interests alone or with other people?

Marital Status

It has become commonplace for couples to live together without being married. I will use the terms *spouse* and *partner* to include any

intimate relationship between two people, without regard to gender or legal status.

You might start by asking:

"Tell me about your spouse." (How does what you hear from the patient square with what you observe?)

"What do you see as the strong points of your relationship?" (Like all open-ended questions, this one gives enough scope to discuss whatever seems important. The report, favorable or not, could indicate the overall state of the relationship.)

Here are some specific items of information you should learn about:

Is the patient currently married?

Are the patient and spouse currently living together?

Have there been any common-law marriages or other long-term relationships?

What are the relative ages of patient and spouse?

How long have they been together?

If they are married, how long did they know one another before the ceremony?

How many marriages has each partner had?

If there have been prior marriages, how old was the patient each time?

Why did prior marriages or other long-term relationships end?

How have emotional problems affected the patient's current relationship?

How well does the partner support the patient during periods of illness or disability?

If the patient is divorced, what were the circumstances of the separation? Who initiated it? Under what circumstances? Do the former spouses still maintain a relationship? If so, how amicable is it?

Issues such as money, sex, children, and relatives commonly provide fodder for contemporary marital disputes. These can develop into mammoth feuds between patients and their families; the burden of mental disorder produces an uncommon variety of arguments, fights, affairs, separations, and divorces. Expect to invest considerable time in—and gain extensive information from—inquiries into the quality of your patient's marriage or other love relationship. Following are some of the questions

you can ask to elicit the sort of routine problems that produce friction in any relationship:

"How well do you and your spouse communicate?" (Some couples almost never have a serious discussion; successful couples take the time to air their grievances, preferences, and points of view.)

"Does each of you consider the other a best friend?"

"How do you argue?" (Are old issues constantly brought up, or do they get laid to rest? Do the partners commonly say things they later regret?)

"What do you argue about?"

If there are children, you should find out:

How many children are there from each marriage?

Are there stepchildren?

What ages and genders are all the children?

Were any children conceived outside marriage?

What is the patient's relationship with each of the children?

Do patient and spouse agree about sharing responsibility for child care?

Questions about sexual adjustment and preference logically belong here. These can be difficult to discuss, so I'll address them in a separate chapter on sensitive subjects (Chapter 9).

Avocations and Interests

OK, so it isn't going to make or break the diagnosis of schizophrenia or a bipolar disorder; still, you want to know something about how your patient spends leisure time (or, for many busy people, would like to spend free time if any became available). What can you infer from hobbies (for example, solitary pastimes such as stamp collecting or photography, outdoor activities such as bird watching) and interests (TV, movies, reading, shopping)? *About 5% of adults identify themselves as compulsive shoppers; such a history could tip you off to other pathology, such as depression, gambling, or binge eating.* Are sporting activities participatory, such as dancing, tennis, or golf, or mainly ones that are viewed from the grandstand (or home theater couch)? Have there been any recent changes in the type or intensity of leisure interests, or in the patient's ability to focus attention while pursuing these interests? If so, can you learn why?

MEDICAL HISTORY

Even if you are not a physician, don't bypass medical history. It is vital for every practitioner to know about this topic and the next one, the review of systems, both of which have practical implications for diagnosis, treatment, and prognosis. For example, a 2007 report pointed out that mentally ill patients die, on average, 25 years earlier than do people in the general population. Fatalities come not only from suicide (though that is a major cause), but from conditions such as heart and lung disease, diabetes, and infectious diseases, including HIV/AIDS. These are all treatable, but first you have to identify them. Furthermore, some symptoms of mental illness may actually indicate treatable medical conditions as ordinary as thyroid problems and Lyme disease. I can assure you that the issues to be covered in these two sections are no more difficult than any of the other areas we have already discussed.

Has your patient had any previous major illnesses? If so, what were they? Did they result in hospitalization? Have there been any operations? If so, what were they? When did they occur? Did the patient ever receive a blood transfusion? If so, is this patient at risk for HIV? If serious medical illness or operations occurred during childhood, how did the patient perceive them at the time? What about allergies to pollen, dust, or animals?

While you are taking this history, you might try to ascertain how well your patient has adhered to recommendations made by physicians and other therapists. Many people, especially those who don't know you very well, may have trouble admitting to poor adherence (which, by the way, we used to call *treatment compliance*). Try asking:

> "Has it always been easy for you to follow your doctor's advice?"
>
> "When have you had difficulty?"

You will find more advice on dealing with difficult patient behaviors in Chapters 16 and 17.

Ask about any obvious physical problems. With sensitive phrasing you can ask just about anything, so don't be shy about bringing up stuttering, an eye patch, a missing limb, or a severe limp. Any of these could have a bearing on the present problem. They may also have prompted teasing during childhood. Even if physical defects are not causing emotional problems now, they may well have done so at some time in the past. You might say:

> "I noticed that you seemed to stammer once or twice while we were talking. I wonder what sort of problems that might have caused when you were a child."
>
> "Children can be pretty cruel about birthmarks. Could you tell me about yours?"

If this is a patient you'll be following into the future, obtain the names of other current health care providers who need to be apprised of treatment and progress.

Medications

In the history of the present illness, you have already learned about the medicines prescribed for emotional disorders. Now ask whether your patient regularly takes any other medications. This information is especially important when the presenting problems include depression, psychosis, or anxiety. Any of these can be caused or made worse by commonly prescribed medications. Pay special attention to birth control pills, other hormones (such as thyroid or steroids), pain pills, and drugs for blood pressure. For each, try to learn dose, frequency, and how long your patient has been taking it. Has the patient recently stopped taking any other medications? *Of course, you are wondering whether withdrawal or side effects could explain the symptoms you are investigating. Keep reading.*

Side Effects

Have there been side effects (unwanted effects) or drug reactions? This topic is often ignored by beginning interviewers, but it can influence the choice of therapies. Try to get a description of the side effect or drug reaction:

What happened?

How long after the first dose did it occur?

Was treatment needed?

If the patient ever tried the drug again, did it produce the same reaction? *Patients may assume that a drug has caused physical or mental symptoms when the two events were only coincidental. The question of cause and effect is sometimes settled when the drug is started again, and the symptoms either reappear or do not.*

You are most likely to hear complaints about rashes developing from sulfa or penicillin, but it is more important to learn about untoward reactions to psychotropic medications. True allergies to these drugs are rare, but side effects are not. Here are some of the more common ones:

Antidepressants: drowsiness, dry mouth, skin rash, dizziness, nausea, weight gain, blurred vision, constipation

Antianxiety agents: drowsiness, dizziness, forgetfulness/confusion

Lithium: skin rash, tremor, excessive urination, thirst

Antipsychotics: low blood pressure, extrapyramidal side effects

Extrapyramidal side effects are neurological symptoms that can be caused by taking antipsychotic medications, especially the older ones. The four types of these symptoms are common enough that every mental health professional can expect to encounter each of them from time to time. The first three occur soon after starting medication and can be treated with antiparkinsonian drugs such as trihexyphenidyl (Artane) or diphenhydramine (Benadryl).

1. *Acute dystonia* develops within a few hours of the first dose of some antipsychotic drugs. It is characterized by a sharp, cramping pain of the neck that may cause the head to turn to the side. Sometimes the eyeballs roll upward. This side effect can be painful and frightening, and can constitute a real emergency.

2. *Akathisia* usually begins within a few days of starting one of the older antipsychotics. Patients experience it as a profound restlessness, often with an inability to sit still that results in pacing.

3. *Pseudoparkinsonism* also occurs soon after starting medication. The patient experiences a decreased mobility of facial expression (*masked facies*); a tendency to walk with short, shuffling steps; and a back-and-forth tremor of the hands when they are relaxed, as when resting in the patient's lap. This tremor resembles the motion that old-time druggists would use to form drugs into pills; hence the term *pill-rolling tremor.*

4. *Tardive dyskinesia* usually does not begin until the patient has been using one of the older antipsychotics for months or years. Someone with tardive dyskinesia typically has uncontrollable motions of the tongue, jaw, and lips that result in persistent pursing, chewing, or licking movements. Patients themselves are often almost entirely unaware that they are doing this; it is not a debilitating disorder, but it is unsightly. *Tardive dyskinesia is all the more important because it has no specific treatment. Unless the antipsychotic drug is discontinued quickly, this side effect can become permanent, persisting even after the medication is eventually stopped.*

REVIEW OF SYSTEMS

In the review of systems, you ask patients to identify any symptoms they have had from a list that you recite. This list comprises symptoms from all the different organ systems of the body. The rationale for using it is that patients will recognize more symptoms by passive identification than they will report if you depend upon their spontaneous, active recall.

A complete medical review of systems is long and not especially relevant to the initial mental health examination. However, you should ask about the following:

Disturbance of appetite *(found in severe depression, anorexia nervosa, and bulimia nervosa; over- or undereating may begin as early as childhood).*

Habits. We often forget to inquire about everyday habits such as tobacco use.

Head injury from sources as diverse as automobile accidents, explosions during military operations, and the cumulative effect of repetitive sporting injuries. *The resulting cognitive disorders can range from relatively brief concussion to the devastation of major neurocognitive disorder (dementia).*

History of unconsciousness, dizziness, or fainting spells *(suggests cognitive disorders or somatic symptom disorders).*

Convulsions (seizures). These may be either biological or psychogenic in origin. Ask about these symptoms: loss of consciousness, loss of control of bowels or bladder, tongue biting, and auras (any premonition or sensation warning the patient that a seizure is about to begin).

Symptoms of premenstrual dysphoric disorder. Before the onset of menses, there may be persistent anger, labile mood, trouble with sleep, fatigue, tension, trouble concentrating, and physical symptoms such as weight gain. *Premenstrual dysphoric disorder is easy to ignore, especially if you are a male interviewer. But it is fairly common among women of childbearing age and can cause symptoms of depression.*

Conversion Symptoms and Somatization Disorder

In addition to these general-purpose questions, mental health clinicians (well, actually *all* health care providers need to consider these issues) can use a specialized review of systems to diagnose what DSM-5 now calls somatic symptom and related disorders, which are encountered fairly frequently in mental health populations. These chronic illnesses, which usually begin in the teens or early 20s, have been given different names and identified by criteria sets of varying rigor over the past half century. I've discussed one of them further under "Somatization Disorder" in Appendix B (pp. 298–300).

FAMILY HISTORY

With the family history, you have the opportunity to accomplish three tasks: (1) develop a brief biographical sketch of parents, siblings, spouse (or significant other), and children; (2) learn about the relationships between patient and relatives, both current and during childhood; and (3) learn whether any mental disorders occur in your patient's family,

including distant relatives. (Remember that a familial disorder could be transmitted through either a genetic or an environmental mechanism.)

You might start with an open-ended request for information about your patient's current family at home:

"Tell me how you get along with your [spouse, children]."

"What sort of people are [were] your parents?"

A few additional probing questions along these lines should help you answer the first two questions about family history. Keep in mind that you should obtain your patient's assessment of both the childhood and adult families.

By this time you have probably already learned such basics as parents' occupations and ages of siblings, but you might not know how much contact your patient has had with them as an adult. If there have been ruptures of these relationships, find out why. The answer could tell you something about the personalities of the relatives, and also of your patient.

To learn what sort of mental disorders may run in your patient's family, you'll need to be explicit. Naturally, you'll want to know whether any blood relatives had symptoms similar to the patient's, but to make clear what you are looking for, carefully define the disorders and the relatives you are inquiring about:

"I'd like to know whether any of your blood relatives ever had any nervous or mental disorders. By 'blood relatives,' I mean your parents, brothers, sisters, grandparents, uncles, aunts, cousins, nieces, nephews, and children. Has any of these people ever had nervousness, nervous breakdown, psychosis or schizophrenia, depression, problems from drug or alcohol dependence, suicide or suicide attempts, delinquency, a lot of medical complaints that no one could find a reason for, mental hospitalization, or arrests or incarcerations? Any relatives who were considered odd or eccentric, or who had difficult personalities?"

This would be a long speech, but you can move through the list of disorders slowly enough to give your patient time to think, and probe for details of any positive answers. Just the fact that someone (even a mental health professional) diagnosed Cousin Louise as having schizophrenia doesn't guarantee that this is what's wrong with her. The relative could have misunderstood the diagnosis, or the clinician could have made mistakes. Try to learn Louise's age when she fell ill and what her symptoms were. What sort of treatment did she receive? How did she respond? What was the ultimate outcome—chronic illness? Complete recovery? Did she ever have another episode?

PERSONALITY TRAITS AND DISORDERS

We can define *personality* as the combination of all the mental, emotional, behavioral, and social aspects that make us individual human beings. The term *character* is often used synonymously with *personality*. The way individuals perceive, think about, and relate to the environment and to themselves form patterns of behavior called *personality traits* that persist for long periods of time, often throughout life. Personality (or character) traits can be detected as early as the first few months of life; they shape behavior forever after and often become even more pronounced with advancing age. These patterns govern relationships with friends, lovers, bosses, and colleagues, as well as with more casual social contacts.

Much of one's personality is under the surface, not readily apparent to others or even to the individual. Psychological testing can help reveal aspects of your patient's personality, but you probably won't have this sort of material available during an initial interview. Your own impression will often depend upon several sources of information:

- Your patient's self-assessment
- Interviews with people who know the patient well (covered in Chapter 15)
- Information about relationships, attitudes, and behaviors with other people
- Behaviors you observe during your interview session

The Patient's Self-Assessment

Try to learn what characterized your patient's personality prior to the first episode of mental disorder; this is sometimes called the *premorbid personality*. Some of the following open-ended questions may help you evaluate premorbid personality:

"Describe yourself for me."

If the response to this open-ended invitation is "What do you mean?" you could prompt with some of the following questions:

- "What sort of a person are you normally?" (Watch especially for answers indicating self-esteem that is either low or inflated, or for responses that contradict facts you already know.)
- "What do you like best about yourself?"
- "What is your mood normally?"
- "What were you like as a teenager?"

Be especially alert for evidence of lifelong behavior patterns. Your patient may use certain phrases that will tip you off:

"For as long as I can remember, I've made friends easily."

"All my life I've been an 'up' sort of person—until my illness."

The two examples just given suggest behaviors and attitudes that generally work well for people. Indeed, in assessing personality it is important not to focus solely on weaknesses, but on strengths as well. For example, how would you describe your patient's intelligence? Previous successes? Coping skills? Support system? Information about hobbies and other interests (see "Avocations and Interests," above) may provide additional clues.

Don't let your quest for psychopathology blind you to the predictive power of a normal premorbid personality. A preponderance of positive character traits suggests that your patient will be less inconvenienced by the current illness, will enjoy better social support while ill and, once the current siege has lifted, will have a better chance for eventually returning to complete mental health.

Following is a list of personality characteristics that are generally considered positive:

Agreeable	Inquisitive
Charming	Open
Cheerful	Optimistic
Confident	Outgoing
Conscientious	Punctual
Dependable	Relaxed
Forgiving	Steady
Independent	Trusting

In the initial mental health interview, you'll often encounter lifelong patterns of maladjustment or interpersonal conflicts. Here are some typical self-evaluations from patients:

"I've always been an anxious, tense person. Kinda depressed."

"I've been a loner all my life."

"People are no damn good. I don't like them; they don't like me."

"I've never felt comfortable around people—not unless I was drinking."

"I've never been successful the way I'd hoped."

"As long as I can remember, I have avoided conflict, whatever the cost."

A list of some of these negative personality traits would include the following:

Aggressive
Anxious
Changeable
Compulsive
Controlling
Fussy
Gloomy
Histrionic
Introverted
Irritable
Jealous
Neurotic
Passive
Perfectionistic
Quarrelsome
Resentful
Rigid
Self-centered
Suspicious
Shy
Tense
Volatile
Worrisome

A few other traits could be read as positive, negative, or neither:

Demonstrative
Meticulous
Reserved
Sensitive
Serious

Relationships with Others

If all you have is a single interview, you may have trouble assessing personality. Some mental health patients give distorted assessments: The picture you obtain may be either too gloomy or overly optimistic. Still, you might obtain valuable information by trying to learn how others view your patient—from the patient's own perspective:

"What sorts of situations do people think you have trouble handling?"

"How well do you control your temper?"

"Does anyone in your family think you have a problem with [alcohol, drugs, your temper]?"

What can you learn about your patient's prejudices and regard for other people? Ask:

"How do you feel about your boss?"

"Is your spouse always as supportive as you'd like?"

"Is there anyone—any type of person—you can't stand?"

Although I ordinarily try to avoid them, questions beginning with "Why . . ." may help sort out your patient's motivations and style of relating to other people:

"Why do you think your brother wants your mother to move in with him?"

"You said you can't work well with one of your partners. Why is that?"

A more objective indicator of personality traits is the history, as it is related by the patient and especially by informants. For example, from the employment history, you could learn something about your patient's adherence to the work ethic: Consider the age of first employment, number of jobs, pattern of employment (intermittent? unbroken?), and history of moonlighting. From the marital history, you can learn about your patient's fidelity and capacity for forming relationships. Throughout the history, you will have examples of how your patient has responded to various stressors.

Rather than taking what you see or hear at face value, try to evaluate all of this information against behavior you already know about. For example, suppose you have already heard that a sibling was favored by their father, and that ethnicity gives a co-worker the inside track to promotion. How do these opinions square with your patient's claim to being an open and trusting person?

Observed Behaviors

Some of the behaviors you observe during the interview may reveal important character traits. Watch for actions or comments that seem to go beyond what you would expect during an interview situation. For example, your patient:

Yawns, slouches, gazes about the room, and otherwise appears uninterested

Invades your personal space by picking things up from your desk

Asks for time out to smoke a cigarette

Repeatedly questions your credentials as a therapist

Criticizes your clothing or hairstyle

Uses strong language to express prejudice against some ethnic or religious group

Tries to argue about something you have said

Brags about qualities that others might seek to conceal, such as sexual liaisons, physical aggression, illegal activities, or substance use

Diagnosing Personality Disorder

By itself, none of the behaviors I've mentioned above can be definitive for actual character pathology. In aggregate, however, or combined with your historical information, behaviors such as these may suggest a *personality disorder*. This diagnosis is made only when character traits are so inflexible and poorly adapted to the requirements of life that they cause considerable distress or impair the person's functioning in the realms of social life, work, or other areas.

A personality disorder isn't so much an illness as a way of life, in which long-standing behavior causes problems for the patient and for others. It often has its roots in childhood and may stem either from environmental influences or from the patient's inherited genetic material; sometimes both are implicated.

The diagnosis of a personality disorder hinges on problems of functioning within the self (either the person's *identity* or ability to provide *self-direction*) and with other people (this person's capacity for *empathy* or *intimacy*). The ensuing pathological character traits continue through a lifetime and affect both patients and those who interact with them.

To give the flavor of personality disorders, below I've included brief definitions of some that have been recognized for decades. The six asterisked examples are generally considered to have better validity than the rest; I've discussed them in greater detail in Appendix B (p. 300).

Antisocial.* The irresponsible, often criminal behavior of these people begins in childhood or early adolescence. Pathological childhood behavior includes truancy, running away, cruelty, fighting, destructiveness, lying, stealing, and robbery. As adults, they may also default on debts, fail to care for dependents, fail to maintain monogamous relationships, and show no remorse for their behavior.

Avoidant.* These timid people are so easily wounded by criticism that they hesitate to become involved with others. They may fear the embarrassment of showing emotion or of saying things that seem foolish. They may have no close friends, and they exaggerate the risks of undertaking pursuits outside their usual routines.

Borderline.* These impulsive people make recurrent suicide threats or attempts. Affectively unstable, they often show intense, inappropriate anger. They feel empty or bored, and they frantically try to avoid

abandonment. They are uncertain about who they are and unable to maintain stable interpersonal relationships.

Dependent. These people have trouble starting projects or making independent decisions, even to the extent of agreeing with others who may be wrong. Often preoccupied with fears of abandonment, they feel helpless when alone and miserable when relationships end. They are easily hurt by criticism and will volunteer for unpleasant tasks to gain people's favor.

Histrionic. Overly emotional, vague, and attention-seeking, these patients need constant reassurance about their attractiveness. They may be self-centered and sexually seductive.

Narcissistic.* These people are self-important and often preoccupied with envy, fantasies of success, or ruminations about the uniqueness of their own problems. Their sense of entitlement and lack of empathy may cause them to take advantage of others. They vigorously reject criticism, and need constant attention and admiration.

Obsessive–compulsive.* Perfectionism and rigidity characterize these people. Often workaholics, they tend to be indecisive, excessively scrupulous, and preoccupied with detail. They insist that others do things their way. They have trouble expressing affection, tend to lack generosity, and may even resist throwing away worthless objects they no longer need.

Paranoid. These people expect to be threatened or humiliated; other people's behavior seems to confirm these expectations. They can be quick to take offense and slow to forgive; often they have few confidants, question the loyalty of others, and read hidden meaning into innocent remarks.

Schizoid. These patients care little for social relationships, have a restricted emotional range, and seem indifferent to criticism or praise. Tending to be solitary, they avoid close (including sexual) relationships.

Schizotypal.* Such patients have so much difficulty with interpersonal relationships that they appear peculiar or strange to others. Lacking close friends, they are uncomfortable in social situations. They may show suspiciousness, unusual perceptions or thinking, an eccentric manner of speaking, and inappropriate affect.

In considering these descriptions, we need to keep some points in mind. For one, many people, perhaps the majority of our patients, have distressing social problems that are *not* caused by a personality disorder. A tyrannical boss can create dissension at work; a psychotic spouse wreaks havoc with a marriage. Chronic psychosis can alienate patients

from their families. Every day, kids use drugs, and the stock market swallows someone's savings. What I'm saying is that many problems people face (and carry to mental health care providers, requesting help) must be viewed through the lens of everyday experience; they represent a too-often-ignored common boundary with normality.

We also need to make sure that a behavior pattern hasn't been caused by, say, a major health problem such as a mood disorder, substance misuse, or a medical condition. We protect against this sort of error by doing a complete history and asking about other mental and behavior systems during the information-gathering phase of evaluation.

The last point we must remember has to do with the limitations inherent in a single interview, no matter how careful and extensive. Especially with personality disorder, the material we need for diagnosis may be revealed only as time deepens our experience with each patient.

CHAPTER 9

Sensitive Subjects

Summoning the courage to cover certain subjects can be a challenge. Though the material itself is pretty straightforward, our society largely regards these sensitive areas—sex, substance use, violence, and suicidal behavior—as deeply personal. After all, questions about these topics potentially threaten an individual's self-esteem and sense of security. Consequently, the patient may feel guilt or shame, whereas the interviewer must cast aside a lifetime of habit, personal doubts, and perhaps bias.

I think it helps to realize that in the clinical interview, we essentially redefine what's acceptable in human interaction. In the role of patient, people expect to be queried on topics that are ordinarily private, and will freely disclose to an unfamiliar clinician information they'd withhold even from close friends. In turn, we clinicians must steel ourselves to the task of broaching topics that we might prefer not to explore in other situations.

Because these topics are critically important to every interview, if your patient does not mention them spontaneously, you must introduce them yourself. You may delay until the latter portions of the interview, after you know the patient a little better, but don't wait until the very end: You could run out of time and still have important material yet to cover. Any interviewer who ignores these areas risks committing serious clinical errors.

SUICIDAL BEHAVIOR

Delving into suicidal behavior is an absolute must. This rule holds even if there has been no hint of death wishes or suicidal ideas at any time during the interview. To violate the rule risks ignoring potentially life-threatening

ideas and behaviors in a patient who may be too ashamed or too embarrassed to mention them spontaneously. Although the vast majority of mental health patients do not kill themselves, nearly every mental health diagnosis confers some degree of suicide risk beyond that found in the general population.

When asking about suicidal behavior, you may feel some discomfort of your own. Beginning interviewers sometimes worry that mentioning this topic could plant the idea in a patient's mind. The truth is that any patient at serious risk for suicide will have considered it long before anyone thinks to ask. The real risk lies in not asking soon enough. Then you might learn only too late how gravely ill your patient really was.

If your patient raises the topic, you can pursue it with a degree of comfort. If such an opening does not occur, it is vitally important that you broach the question yourself. Unless your patient seems unusually uncomfortable, you don't need to precede these questions with apologies or explanations. Most patients will feel about as comfortable as you appear to feel.

In the context of the mental health interview, it is perfectly all right simply to ask:

> "Have you ever had any thoughts of hurting or killing yourself?"

If the answer is "No," and this seems to jibe with the patient's mood and recent behavior, you can accept it as simple fact and move on to another topic. If the response is equivocal or delivered with telltale body language, such as a hesitating manner or suddenly downcast gaze, you must pursue the matter with further questioning. Studies show that more than 10% of those who have attempted suicide will eventually die by suicide, and that this risk can persist for decades after the initial attempt.

Of course, you must also be careful not to damage rapport. Should your questioning seem to cause increasing discomfort (prolonged hesitation, tears), you may need to comment on the distress:

> "You look so sad that I hate to pursue this subject, but I really feel that I must."

To someone who has attempted suicide or has been otherwise violent, you might say:

> "Your recent experience makes me worry that you might try it again. Has anything changed that might influence you one way or another?"

Some clinicians believe that patients may respond more truthfully if you avoid the "S-word," *suicide*. This seems a bit far-fetched to me, but if

you wish, you can gradually work toward your goal with a series of increasingly explicit questions:

1. "Have you been having any disturbing or gloomy thoughts?"
2. "Have any of these thoughts been desperate ones?"
3. "Have you ever wished you were dead?"
4. "Have you thought about harming yourself?"
5. "Have you made any plans to take your own life?"
6. "Have you ever made any actual attempts?"

It is important to expand upon a "Yes" answer to any of the questions above by asking a suitable, open-ended follow-up question:

"Could you tell me some more about that?"

"What happened then?"

If the actual attempts occurred prior to this episode—sometimes in the distant past—memories may be dim. But you should learn as much as you can about previous attempts. The information will help you (1) predict what your patient might do next, and (2) assess what actions you should take. So get answers to these questions:

- How many previous attempts have there been?
- When did they occur?
- Where was the patient at the time?
- What was the patient's mood at the time?
- What methods were used for the attempts?
- Was the attempt made under the influence of drugs or alcohol? (If so, had there been other attempts when the patient was clean and sober?)
- Did the patient have other mental symptoms at the time? (In addition to substance use, you especially should learn about depression and psychosis.)
- What were the stressors that preceded the suicidal behavior? (Look for such losses as separation or divorce, death of a loved one, job loss, or retirement. However, any upsetting event in the life of the patient or of a friend or relative could serve as a precipitant.)
- What kept the person from completing suicide in the past? (Family considerations? Religious concerns?)
- How serious were the attempts?

Although studies demonstrate that those who actually follow through and commit suicide are likely to have certain characteristics—classically,

they are old, white, unmarried, jobless, physically ill men who drink and have depression or psychosis—you cannot rely on the absence of any (or even all) of these features to protect your patient from self-harm. Neither can you rely on a "no-suicide" contract with the patient, the principal effect of which may be to reduce your own anxiety.

Physical and Psychological Seriousness

We can judge the seriousness of a suicide attempt in each of two ways: (1) How physically harmful was the attempt? (2) How strong was the patient's intent to die? An attempt that is serious either physically or psychologically increases the likelihood that this patient will commit suicide in the future. When you are assessing a new patient for suicide potential, you should have these guidelines in mind.

A suicide attempt is physically serious when it results (or could result) in significant bodily harm. By this standard, a severed jugular vein, a deep coma, or a gunshot wound to the chest would be a physically serious attempt. So would be the ingestion of 100 tricyclic antidepressant tablets, even if the patient's stomach is pumped before coma sets in. Without prompt medical attention, fewer than half that number of antidepressants could be fatal.

At the other extreme are those attempts that are highly unlikely to cause any serious harm, let alone death. They include such acts as lightly scratching the wrist or swallowing four or five aspirin tablets. Such behaviors, which are sometimes called "gestures," suggest that the patient had in mind some purpose other than dying. In making this judgment, you set aside the physical implications and consider the psychological seriousness of the attempt, to learn what intention lay behind it. Was there a genuine wish to die, or was it a cry for help? Here are some of the possible motives for attempted suicide:

A genuine wish to die

The desire to attract help

Escape from some intolerable situation

Relief from mental distress

An attempt to influence someone's attitude or behavior

Many patients who have made psychologically serious attempts can clearly state their feelings:

"I'm sorry I didn't succeed."

"I'll try it again."

Others may be less clear, or perhaps ambivalent. You must ask them:

"What did you think would be the outcome of your overdose [or other attempt]?"

For some, your best course could be to infer intention from behavior. The patient who attempts suicide alone in a hotel room under an assumed name is clearly more bent on self-destruction than is one whose attempt occurs at home just before the expected return of a spouse.

Here are some other questions that can help you judge the psychological seriousness of intent:

"Did you impulsively decide to make the attempt, or had you been planning it for a while?" *Planning and preparation are usually associated with more serious attempts.*

"Before the attempt, had you written or revised a will, given away property, or taken out life insurance?" *Any of these behaviors suggests serious plans.*

"Did you write a suicide note?" *More evidence of planning.*

"Was someone with you when you made the attempt?" *A "yes" answer suggests that the patient had arranged a means of rescue.*

"What did you do after you made the attempt?" (Lie down to wait for the end? Call for help? Phone a suicide hotline?) *Inaction should ring an alarm.*

"How did you feel when you were rescued?" *"Angry" sounds more serious than "relieved."*

You must correlate whatever you learn about these previous suicide ideas and attempts with your patient's current thinking on the subject. It is vital to learn about ideas or plans that could prove lethal, especially within the next few hours or days. Ask:

"Have you felt suicidal recently?"

"What have been your thoughts about it?"

"Have you made any plans?"

(If so:) "What are they?"

"Do you think you are likely to carry them out?"

"What has stopped you in the past?"

"When is it likely to happen?"

"What effect do you think it would have on others?"

"Do you feel you have any reason to live?"

"Could anything make suicide seem less attractive?"

"Do you own a gun? Or have access to one?" (Of suicide attempts made by firearms, 85% are fatal; only 2% of attempts made with pills succeed.)

As a general rule, I avoid using the term *manipulative* in describing a suicide attempt. For one thing, most patients who attempt (or complete) suicide are somewhat ambivalent about their actions, so most attempts are to varying degrees both sincere *and* cries for help. More important, *manipulative* tends to cause clinicians and families alike to relax their vigilance at a time when they may need it most.

Any current ideas or plans that could prove harmful require rapid action. If you are a student, this means contacting the treating clinician at once, to be certain that the patient's thoughts and plans are fully known. This action on your part is essential, even if it means violating a confidence or promise of confidentiality you have made previously. *Preventing suicide and other harm to patients and those around them is an absolute duty of every health care professional. To carry out this duty effectively, all clinicians must feel confident that everyone who has contact with the patient will share vital information. If you must break a confidence to ensure safety of a patient or the public, be assured that the vast majority of patients will not blame you for your action. In fact, most patients later feel grateful for such a life-saving "betrayal."*

VIOLENCE AND ITS PREVENTION

Violence toward others is relatively uncommon, but because of its serious implications for patients and for intended victims, it's at least as important to learn about as is suicidal behavior. Keep in mind that it is vital to assess not just current thoughts and ideas, but the history of violent ideas and behaviors as well. Hence the usual form of these questions is "Have you *ever* [had thoughts of harming another person]?"

If your patient admits to legal difficulties such as arrests or time in confinement, you will have a natural lead-in to questions about violence. Much violence is domestic, so another good time to inquire is when you learn that the patient is divorced or has been a partner in a troubled marriage. (Don't neglect to learn about beatings or other mistreatment that the patient might have received *from* a domestic partner.)

If no natural lead-in occurs, you will have to raise the subject. As with self-harm, you can work up to it gradually:

1. "Have you ever had feelings of uncontrollable rage?"
2. "Have you had any thoughts about harming others?"
3. "Have you ever had trouble controlling your impulses?"
4. "As an adult, have you ever been involved in fights?"
5. "Have you ever brandished a weapon in anger?"
6. "Were you ever arrested for fighting or for other violent behavior?"

Positive answers must be explored:

"What were the circumstances of the violent [thoughts, acts]?"

"When did they occur?"

"Who was involved?"

"How did you feel about this?"

"Did the behavior involve substance use?"

"What was the effect on the other person?"

"What happened to you as a result?"

"Were you arrested?"

"Were you convicted?"

"How much time did you serve?"

Phillip Resnick notes that when interviewing a patient who has persecutory ideas, you may get little response from a generic "Have you had thoughts of harming anyone?" because, under ordinary circumstances, this person may indeed have no such ideas. But if the person is faced with the hypothetical prospect of confronting the imagined persecutor, underlying feelings may surface. Ask instead, "Suppose [an FBI agent, your brother-in-law] parked in front of your house and rang the bell. What would you do then?" The answer may reveal the potential result of your patient's antipathy.

In all instances, try to understand what lies behind your patient's violent ideas or behavior, and what might be causing these feelings. You might find, for example:

Anger at a motorist who has damaged the patient's car

Depression that results from genetic inheritance plus heavy drinking

Envy of a co-worker who has won a coveted promotion to vice-president

Frustration that the Internal Revenue Service continues to send dunning notices for an assessment the patient has already paid

Greed when confronted with the possibility of inheriting a large estate

Hatred for an ex-spouse

Revenge for a sister's death at the hands of a mugger

A temptation for anyone, including a highly experienced clinician, who interviews a potentially violent patient is to become immersed in obtaining the relevant information, to the exclusion of all other considerations. The principal one of these should be personal safety. I don't mean to alarm anyone; your risk from any given patient is small. Yet one survey found that over half of mental health professionals had been threatened or assaulted by a patient within the previous year. Years ago, I was the target of a battering patient, and it is something I'll go a long way to prevent happening again. In a nutshell, here's how to set about it.

1. Ensure that you have an unimpeded escape route from the room where you are working. This means that there should be no one and nothing between you and the exit.

2. Make sure that someone is within earshot or can instantly answer a warning buzzer or other alarm.

3. Be especially alert when your patient has a prior history of violence; the recidivism rate for assault is sky-high. The danger is especially great for a patient who should be taking antipsychotic drugs, but isn't.

4. Keep alert to the nuances of voice (rising pitch or tempo), words (threats and insults), and body language (narrowed gaze, agitated pacing, a clenched fist) that could signal imminent action.

5. As soon as you sense danger, act. You'll need to put aside your usual instincts about soothing the patient (no leaning close to provide comfort, no touching for reassurance). Instead, announce calmly what you're about to do—"Mr. Smyth, I'm getting up and walking to the door"—a verbal warning to avert sudden alarm in a startled patient. Then do just as you've promised.

6. Once you are out of the room, get help from anyone who is available: other staff, building security, or police.

As for your office, every inpatient or outpatient facility should have a set of emergency procedures to serve as the basis for drills. The details will involve deciding who calls 911, who shows up at the door to answer any sort of alarm, and how to present a show of force in a manner that is as casual and nonthreatening as possible under the circumstances.

SUBSTANCE MISUSE

At least 1 of every 13 adult Americans has a problem with substance misuse. The figure is even higher among mental health patients, of whom perhaps 25% misuse substances, and much higher in some specialized clinics. Some experience with substances that can be misused has become almost a rite of passage for American teenagers. It is so common—and its effects upon patient and environment can be so far-reaching—that substance use must be covered in the initial interview of every mental health patient, regardless of sex, age, or presenting complaint.

Alcohol

Despite the educational efforts of mental health professionals and Twelve-Step organizations like Alcoholics Anonymous (AA), many people still view substance misuse as a moral failing. As a result, patients and interviewers alike find this issue difficult to discuss. Perhaps you can find a natural lead-in. Some family history might tip you off.

> PATIENT: So you can see, my childhood was nearly ruined by Mom's drinking.
>
> INTERVIEWER: Sounds pretty difficult, all right. And what about you—do you do any drinking yourself?

Just at that moment it might be inconvenient to change course, as this interviewer did, and pursue a new subject. You might instead decide to keep on eliciting childhood history and later refer back to what the patient said about family history:

> INTERVIEWER: A few minutes ago you mentioned your mother's drinking. It made me wonder—have you ever been a heavy drinker yourself?

If your patient doesn't raise the subject of drug and alcohol use, you will have to create your own opportunity. Alcohol is more socially acceptable than other substances, so you can ask about it with less risk of embarrassment. Assume that your patient, like most adults, is no teetotaler. You will be right more often than not, and the assumption of some drinking may ease the stigma if your patient's drinking has been excessive. Find out how often and how much your patient drinks:

> "Now I'd like to know about some of your habits. First, in an average month, on how many days do you have at least one drink of alcohol?"

Note how the form of this question requests a precise answer, framed in terms of days per month. This discourages vague or evasive answers such as "Not very much" or "Only on social occasions." (You can count the following drinks as having roughly the same alcohol content: a 12-ounce beer, a 6-ounce glass of wine, and a 1-ounce shot of 80-proof hard liquor.)

Next you might ask:

> "On the average day that you have at least one drink, how many drinks do you usually have?"

These two numbers—drinks per day and days per month—allow you to calculate your patient's average number of drinks per month. As you do more interviews, you will develop a feel for what is usual and what is excessive. More than 60 drinks per month (2 per day, on average) is worrisome; more than 100 per month is far above the norm. But even a number below 60 can suggest a drinking problem if many of the drinks are consumed over just a few individual days: Binge drinking is one of the possible patterns of substance misuse.

Even if the patient denies current heavy drinking, learn how much drinking there has been in the past. Has the patient been a lifelong teetotaler, or is this a recent change? ("I don't touch alcohol" may mean "I haven't had a drink since Sunday. For breakfast.") Ask:

> "Was there ever a time in your life when you used alcohol more heavily than you do now?"

Obtain follow-up information about days per month, drinks per day, and the reasons for stopping.

Alcoholism (DSM-5 now calls it alcohol use disorder) is a condition defined by its consequences. The amount a person consumes is an important clue, but the diagnosis itself depends on the effects of drinking on the individual, as well as on the effects the individual then has on other people. Therefore, unless your patient denies ever having a problem with drinking, you will need to ask questions about several categories of consequences.

For *medical problems*, ask:

> "Has drinking caused you to have liver trouble, vomiting spells, or other medical problems?"
>
> "Were you ever told to quit drinking because of your health? And did you?"
>
> "Have you ever suffered from blackouts? This means that the morning after drinking, you can't remember what happened the night before."

(As demonstrated in this question, be sure to define what you mean by *blackout*—some patients won't know the term.)

One criterion for alcohol (or any substance) use disorder is consuming more than the patient intends. This is sometimes difficult to evaluate—especially with teenagers, who aren't known for setting limits, but rather drink for the effect it provides. Instead, try to ascertain *loss of control*:

"Have you ever tried to quit drinking?"

"Have you ever set rules about drinking, such as 'Never drink before four in the afternoon?'"

"Do you ever gulp drinks?"

"Once you take your first drink, do you have trouble stopping?"

For *personal and interpersonal problems*, ask:

"Do you sometimes feel guilty about how much you drink?"

"Have you ever gotten into fights when drinking?"

"Has drinking ever caused a divorce or other serious domestic problems?"

"Has it lost you friends?"

For *job problems*, ask:

"Has drinking ever caused you to be absent from work? Late to work?"

"Have you ever been fired from a job because of drinking?"

For *legal problems*, ask:

"Have you ever been arrested for alcohol-related behavior?"

"Have you had any arrests for driving while intoxicated?" (If so, find out what happened in court.)

"Have you ever caused an accident while driving under the influence?"

For *financial problems*, ask:

"Have you ever spent money on alcohol that should have gone for necessities like food?"

"Have you had any other financial difficulties because of drinking?"

If a question in any of these categories yields a positive response, ask:

"Have you ever been concerned about your drinking?"

"Have you ever thought that you might be an alcoholic?"

"What has been your longest period of sobriety?"

"How did you achieve that?"

"Were you ever treated for the use of alcohol?"

"What happened as a result of treatment?"

Street Drugs

With street drugs, the procedure is similar. Your questions about alcohol use will lead naturally into this subject. Ask:

"Have you ever tried street drugs of any sort?"

When you are speaking of substance use, the word *tried* may carry less stigma than *used*. As with alcohol misuse, you will want to learn when use (it's hard to avoid that word) began, when it ended (if ever), and why the patient stopped using. Define the type of drug; the frequency of use; and the effects of use on the patient, friends, and relatives.

One problem you might encounter is not knowing the slang terminology for drugs commonly misused. If you don't understand a term, just ask; patients love to teach their care providers. I've listed a few of the terms you might hear used, but there are hundreds more. You can find many of them on the Internet (see, for example, *www.njlawman.com/feature%20pieces/drug%20slang.htm*).

Hypnotics: downers, ludes, yellow jackets, tranks, reds, rainbows, Christmas trees

Cocaine: snow, coke, rock, crack

Hallucinogens: LSD, acid, PCP (phencyclidine), mescaline, peyote, STP

Narcotics: H, horse, smack, junk (heroin); schoolboy (codeine); little D (Dilaudid [hydromorphone]); Miss Emma (morphine)

Marijuana: pot, grass, tea, hash, joint, reefer, Mary Jane

Central nervous system stimulants: uppers, bennies, black beauties, crank, speed

Special names may be used by various ethnic groups or in diverse parts of the country, and the terminology is fluid, changing as new cohorts of users come of age.

Prescribed or Over-the-Counter Medications

Don't forget to inquire into overuse of medicines:

> "Have you ever taken more of a prescription medication than your doctor prescribed?"
>
> "Which over-the-counter drugs do you use?" (Nearly everyone uses something.)

Again, you need to know when, what, how much, and what the effects were.

And for any substance, you'd like to know the answer to this question: "What does it do for you that causes you to keep using it?"

SEXUAL LIFE

As a part of consulting a mental health professional, patients expect questions about sex. However, this line of questioning makes some people feel uncomfortable, so you could be better off delaying it until later in the interview. By then you will be better acquainted with the patient, who may view these sensitive issues in the context of other necessary psychological, medical, and social information.

To learn about this important life area, you must be able to discuss it openly, without showing disapproval or censure. Clinicians in training often have difficulty questioning patients about their sex lives. Sometimes this is due to an unfamiliarity with the questions that should be asked, but it may relate to personal standards of sexual conduct—which in turn are the results of upbringing and culture. Here it is vital to recognize your own standards and acknowledge that your patient has the right to a different set. And because a frank discussion of sex can be titillating to both parties, the sexual history is an area where, more than ever, you need a firm grip on your professional boundaries.

During the present illness or the personal and social history, you may have already learned something about the relationship between patient and partner that provides a natural introduction to the subject of sex. If this has not happened, or if the patient has no current partner, a straightforward request for information is in order. An open-ended question will provide both comfort for you and scope for the patient to respond:

"Now I would like you to tell me about your sexual functioning."

The form of this question assumes that most people have sex, and that this is acceptable and normal.

If the first response is a question of the patient's own ("How do you mean?"), you might elaborate as follows:

"I'm trying to learn two things. First, how is your sexual functioning usually? And second, how has it been affected by the problem that brought you into treatment?"

Note that this speech, which deliberately breaks the rule about not asking two questions at once, tells the patient the scope of what you are trying to learn.

The ensuing discussion should give you the following sorts of information:

At what age did the patient first learn about sex?

What was the nature of early sexual experiences?

At what age did they occur?

How did the patient react to them?

Sexual Preference

Some mental health clinicians prefer to start their inquiries about sex with a straightforward question:

"What is your sexual preference?"

This approach has the virtue of (usually) eliciting a clear answer early, and therefore avoiding the possibility of embarrassing misunderstandings later. Be careful not to assume that a patient in a heterosexual relationship has no history of homosexuality.

For anyone with such a history, you should try to learn:

Is the patient bisexual or exclusively homosexual?

If the latter, about what percentage of sexual encounters are heterosexual?

Does the patient find this sexual orientation comfortable (*ego-syntonic*) or uncomfortable (*ego-dystonic*)?

How well has the patient integrated sexual orientation with lifestyle?

Has the patient wanted or attempted to change sexual orientation?

Although reports of dreams are usually not rewarding in an initial interview, the presence of homosexual fantasies can sometimes help in the evaluation of patients who seem unclear as to their basic orientation.

Sexual Practices

When there is a history of sexual difficulty, a great many questions should be asked that you wouldn't routinely explore. Use your common sense; often questions of this nature can be safely postponed until later. Once you have assured yourself that the patient and partner are happy together and function well sexually, you can probably make do with a general question:

"Have there been any issues of a sexual nature that we haven't yet talked about?"

In the event of sexual dysfunction, however, some of the following issues will be appropriate for discussion:

- Has the sexual problem been lifelong, or was it recently acquired?
- What are the current sleeping arrangements?
- Have there been problems with intercourse? (Do they necessitate abstinence?)
- Is sex pleasurable for the patient?
- What about for the partner? (Until sex preference and practices are known, you are safer using "partner" than a gender-specific noun.) *Women are much more likely than men to report lack of sexual pleasure.*
- If the patient is married or in a long-term relationship, have there been outside affairs? If so, how many? How often? How recent?
- Does the couple communicate clearly about sex?
- What is the frequency of sexual relations? Has this changed recently, or with age?
- Who usually initiates sex?
- Are the partners hesitant to approach one another for sex, perhaps due to other interpersonal problems?
- Does the couple use foreplay? How long does it last? What constitutes foreplay? (Talking? Kissing? Genital touching?) *Because many men do not realize that arousal takes longer for a woman than for a man,*

their female partners may report that foreplay is too brief and that intercourse itself is unsatisfying.

- If oral sex is practiced, are both partners enthusiastic about it?
- How often does the patient achieve climax? *Anorgasmia (lack of climax) is fairly common among women, who may nevertheless experience strong sex desire. Some can achieve climax only under certain circumstances, such as with masturbation. As with sexual interest, ability to achieve climax may be decreased by illness (physical or mental) and anxiety.*
- How often does the patient masturbate? Does this represent a problem for either the patient or the partner?
- What method of birth control (if any) does the couple use? Do the partners agree about the timing or prevention of conception?
- Have there been sex partners outside the current relationship?
- Has either partner had any history of sexually transmitted disease?

Common Sexual Issues

Sexual functioning comprises the areas of desire, arousal, and orgasm. Even if desire seems to have waned, does the patient still have sexual thoughts or fantasies? Be alert for several relatively common sexual problems:

Impotence (inability to achieve or maintain erection). How long ago did it start? Is it total or partial? Does it occur only with specific partners? Has it been medically investigated? Treated? Note that impotence is quite different from lack of sexual desire.

Dyspareunia (pain with intercourse). Common in women, it's a condition men rarely report. Its cause can be biological or emotional. Is it pronounced enough to interfere with sexual functioning or pleasure?

Premature ejaculation. When a man too quickly reaches the stage of *ejaculatory inevitability* (to use the Masters and Johnson term), both partners can experience frustration and lack of pleasure.

Delayed ejaculation. This can be the result of emotional factors, such as guilt, or of certain medications. The classic example is thioridazine (Mellaril), which has even been used to treat premature ejaculation.

Concerns about possible homosexuality or bisexuality. Whereas such behavior may be important for the patient, and so constitute legitimate grounds for investigation by a mental health clinician, it is important to make patients aware that it is not considered an illness, rather a variety of normal sexual preference.

When you are learning about the patient's sexual life, ask for specific instances in which the problem arose. If technique seems to be the issue, ask for a description in behavioral terms: "First I . . . then she does . . . but that usually doesn't work, so we . . ." As with a nonsexual problem, find out when it began, how often and under what circumstances it occurs, how severe it is (is it getting worse?), what has been done about it, and what seems to help.

Paraphilias

Relatively less common are the paraphilias, which comprise a number of behaviors in which the patient is aroused by a stimulus other than a consenting adult human, or by the humiliation or suffering of the patient or sexual partner. The diagnosis of a paraphilic disorder (as distinct from a paraphilic behavior) is made only when the desire has occurred repeatedly for least 6 months and when the patient has acted on the urge or has been markedly distressed by it. Almost all such patients are men, and many report having several of these types of urge, which can interfere with the ability to enjoy normal sexual and love relationships. The specific paraphilic disorders are as follows:

Exhibitionistic disorder. These patients have fantasies and urges that involve the sudden exposure of their genitals to an unsuspecting stranger, usually a female. Patients who act upon these fantasies usually neither attempt physical contact with the victim nor pose physical danger.

Fetishistic disorder. Fetishists are sexually aroused by inanimate objects—often shoes or women's underwear, which are used by the patients themselves or are worn by a partner during sexual activity.

Frotteuristic disorder. Frotteurs are aroused by touching or rubbing against a nonconsenting person. Frottage usually takes place in a crowd and may involve contact through clothing with hands or genitals.

Pedophilic disorder. These patients have sexual fantasies and urges about young children (usually age 13 or under). Most pedophiles prefer girls, but some are aroused by boys or by children of either gender. The disorder is usually chronic and may involve various sexual activities, including looking, undressing, and physical contact.

Sexual masochism disorder. The sexual fantasies and behaviors of these patients involve being beaten, bound, or otherwise humiliated or made to suffer. In extreme cases, death from suffocation can result.

Sexual sadism disorder. These patients are sexually aroused by inflicting physical or psychological pain on other persons, who may be either consenting or nonconsenting. Such behavior may increase over time, sometimes resulting in severe injury and even death.

Transvestic disorder. These patients are sexually aroused by cross-dressing. Although the DSM-5 criteria are gender-neutral, only males with transvestic disorder have been reported.

Voyeuristic disorder. Voyeurs ("peeping Toms") are aroused by watching an unsuspecting person who is nude, in the act of disrobing, or having sex.

Other paraphilic disorders. Other paraphilic disorders include sexual arousal from animals, body excretions, cadavers, and "talking dirty" on the telephone.

Sexually Transmitted Diseases

For all patients, be alert for a history of sexually transmitted diseases, including herpes, syphilis, and gonorrhea. Especially ask about risk factors for HIV/AIDS: multiple sex partners, sex with persons who use drugs intravenously, or homosexual relationships. If any answer is "Yes," you'll need to ask whether condoms are used. If so, what percentage of the time? Has the patient ever been tested for HIV? If so, how recently? What were the results?

SEXUAL ABUSE

Childhood Molestation

A history of childhood sexual experience is distressingly common, especially among mental health patients. Yet this area is often left unexplored, even by experienced clinicians. *Childhood sexual experiences have been linked to many adult disorders described in DSM-5, including borderline personality disorder, eating disorders, dissociative identity disorder, and somatic symptom disorder (or, as I prefer to continue calling it, somatization disorder).*

Even if none of these conditions is present, memories of early sexual behavior may present concerns that require discussion and reassurance. Therefore, you must ask. But do so in a way that avoids such loaded terms as *molestation* and *rape*:

"When you were a child, were you ever approached for sex by another child or by an adult?"

"Have you at any time in your life been coerced into having sex?"

Any positive answer should be explored thoroughly. In particular, obtain the following details:

What actually happened?

Was there physical contact?

How old was the patient then?

How many times did the incidents occur?

Who was the perpetrator?

Was there a blood relationship between perpetrator and patient?

How did the patient react to the incident(s)?

Were the parents told?

How did they respond?

How have these incidents affected the patient, either during childhood or as an adult?

An occasional patient will give equivocal answers such as "I'm not sure," or "I really can't remember much about my childhood." Such a response should alert you that somewhere in your patient's background may lie experiences too distressing to be tolerated as conscious memory. Further probing at this time probably won't uncover much additional information, but do try to identify as exactly as possible the interval that has been forgotten ("ages 6 through 12" or "throughout junior high"). It may help later with the memory recovery process.

This is one time when you should probably not alert your patient that you will return to the subject later. A promise to pursue long-buried traumatic memories may seem threatening and could interfere with the rapport you are trying to build. Instead, say:

"It sounds as if you have some doubt about this area. That's all right—nobody remembers everything from childhood. But if anything about early sexual experiences comes back to you later, I'd like to hear about it. It could be important."

Do make a careful note to return to the subject in a later interview, when you're sure your relationship is on solid ground.

Rape and Spouse Abuse

For decades (at least), the crime of rape has been seriously underreported. This fact is probably explained by victims' feelings of shame and embarrassment and their fear of notoriety. With the publicity of "celebrity

rape" trials and our enhanced understanding of victim psychology, these attitudes may have lessened somewhat in recent years. Nonetheless, it remains all too common that patients (the vast majority of them female) have as adults suffered rape or other forms of sexual abuse. (The U.S. military reported that sexual assault increased by 43% in 2012–2013 over the 12 months before.) Mental health interviewers must be able to draw forth the information needed to determine the best course of action for these patients, many of whom have been severely traumatized by their experiences.

Usually the preferred first approach is a sympathetic, unstructured invitation to describe the events and their consequences:

"Please tell me about these experiences."

With gentle, probing questions, you should then try to obtain the following information:

What were the circumstances? (Surroundings? Patient's age?)

Who was the perpetrator? (Relative? Acquaintance? Stranger? Gang?)

How many times did it occur?

Did the patient know the perpetrator?

Were they related?

Was the use of alcohol or drugs involved? If so, by whom?

What emotional reactions did the patient have at the time?

Who has been told?

Has the story been heard sympathetically?

Has legal action been taken? If not, why not?

What have been the lingering effects of the experiences? (Look for fear, anger, shame, anxiety, depression, and symptoms of posttraumatic stress.)

Similar multiple emotions can be evoked by sexual and physical abuse from spouses. Victims may also be reluctant to report this crime for fear of reprisals, such as further abuse or abandonment.

CHAPTER 10

Control of the Later Interview

During most of the early interview, you have encouraged your patient to discuss problems freely. By the time you move on to the personal and social history, you will need to exercise more control over the form of your interview. This will enable you to use your time efficiently to cover all the material and probe the important remaining areas. A number of verbal and nonverbal techniques can help direct the patient's responses and maximize the amount of material you obtain.

TAKE CHARGE

Some patients take direction so well that you can exercise control just by gently interjecting an occasional guiding question. Patients who are circumstantial or perhaps just plain talkative will need more active measures of control. Those with manic pressure of speech or psychotic suspiciousness may require frequent redirection.

Of course, you will have to temper your own verbal output. Novice interviewers must be especially wary: Anxiety sometimes causes them to speak too often or at excessive length. Remember that the main purpose of your questions and interventions is to facilitate the flow of information from the patient. In order to occupy as little time as possible with explanations, state your questions clearly and succinctly.

With the need to cover so much ground, you may not be able to respond as completely as you would like to issues your patient raises. For example, on hearing that your patient was teased as a child, your natural impulse may be to sympathize and ask for examples, effects, and the

patient's reactions. But perhaps it is late in the session, and you still must uncover any history of sexual abuse. You may have to defer some of these natural responses until another session. For now, you could briefly sympathize and then indicate your interest by asking about other childhood traumas you want to investigate anyway.

PATIENT: . . . so I felt that I was the butt of every schoolyard joke and prank.

INTERVIEWER: That sort of experience can really make a kid miserable. Did you have other sorts of distressing problems as a child? For example, did anyone ever approach you about sex?

You should try to avoid abrupt transitions, which can impair rapport. Instead, try one of these techniques:

- You can change the subject with more grace if you first make an empathic comment, as did the interviewer in the example above.
- Stop taking notes and put down your pen. If you continue to write, your patient may feel encouraged to continue talking about the same subject.
- If you must interrupt, try raising your forefinger (raising an entire hand seems peremptory) and taking a breath to signal that you need a turn to speak.
- Try moving quickly to get in a word between two of your patient's sentences. Although this requires vigilance and some verbal dexterity, it usually works well, especially if you manage to intervene at the end of a thought.
- If your patient brings up something that you already have covered sufficiently, indicate the need for a change of direction:

  "I'd like to hear more about that later, if we have time. For now, let's talk instead about . . . "

  "I think I understand about your insomnia. But has your appetite changed any?" (Notice that asking a "yes–no" question suggests that now you'd like a short answer.)

  "I need to interrupt here to ask about something else that's important . . . "
- Nod or smile when you do get the sort of brief answer you want. This reinforcement will encourage further brevity.

But some patients simply don't respond well to hints. For someone who continues to ramble, you may have to be more direct. A good approach is to state clearly your needs and your proposed solution:

"For me to help you best, it's important that we cover a lot of ground. That means we'll have to move on now to another area."

"Our time is getting a little short . . ."

"Let's stick with the main topic . . ."

You may have to indicate the new direction more than once before an especially talkative patient gets the message. But keep at it—you must obtain all of your diagnostic material.

CLOSED-ENDED QUESTIONS

For the earlier portions of the interview, I've recommended open-ended questions, because they help patients communicate with greater clarity and scope. Later in the interview, when you know what sort of specific information may be relevant to diagnosis and therapy, closed-ended questions work especially well.

Closed-ended questions are those that can be answered "Yes" or "No," or that request a specific answer (such as a number, the patient's place of birth, or another fact such as a name or the duration of a marriage). They allow you to pin down diagnostic criteria and clarify previous responses, so you obtain the specifics of your patient's problems. They also discourage evasiveness on the part of a patient who would like to hold back certain information. In addition, they will help you ascertain significant negatives, such as the absence of sexual problems or psychosis; from open-ended questions alone, you might not learn that your patient doesn't have these symptoms.

Another closed-ended technique is to substitute a multiple-choice request when your patient can't answer a question that is less well defined:

INTERVIEWER: For about how long have you been using cocaine?

PATIENT: Well, I . . . that is . . . uh, I don't know exactly.

INTERVIEWER: Well, has it been 1 week or 2, or more like 6 months, or perhaps a year or more?

PATIENT: Oh, it's been over a year. Maybe 3 years, anyway.

You should also be aware of the potential drawbacks of closed-ended questions. Patients who are more verbal may resent closed-ended questions if they think you care more about the process of getting the information than you do about the person who is supplying it. Also, the "yes–no" format denies patients the chance to give a gradient of response. The answer you get could mislead rather than educate you. Here is an unfortunate example:

INTERVIEWER: Did you have problems relating to your father when you were a child?

PATIENT: (*Thinking,* "Let's see, I couldn't stand the Old Man, so I never paid any attention to what he said. I guess the answer I can give is . . . ") No.

Closed-ended questions can be valuable, but you should avoid suggesting how you would like your patient to answer. Such *leading* questions broadly hint that there are certain standards or behaviors you approve of. A leading question severely limits the scope and validity of the information you will obtain. For example, don't indicate your idea of "average":

INTERVIEWER: How much alcohol do you drink?

PATIENT: Oh, I'd say it's about average.

INTERVIEWER: Two or three times a week?

PATIENT: Well, sure.

A better response for this interviewer would have been "What is 'average' for you?" In fact, beware of any leading formulation that suggests what you regard as normal. Instead of "Is your relationship with your father a good one?" try the open-ended "How do you get along with your father?"

Closed-ended questions may actually inhibit some patients from responding fully. This is why you should mostly use them later in the interview, after you have built rapport and your patient has developed the habit of giving full responses. Because they require you to do a larger share of the talking, closed-ended questions give the patient more time to screen out replies that are embarrassing or that seem "irrelevant." In consequence, the information you gather could prove false or incomplete.

Nevertheless, this highly structured style of requesting information may be appropriate for someone who isn't used to the interview process or who has limited verbal skills. This will apply especially to patients with severe mental illnesses, such as cognitive disorders or untreated schizophrenia; to some who have subnormal intellectual abilities; and to those who, for a variety of reasons, are reluctant to be interviewed in the first place. Such patients may require extensive use of "yes–no" questions.

Regardless of how far you have progressed in the interview, you will probably succeed best if you continue to use a mixture of open- and closed-ended questions. For example, after you have obtained a string of rapid-fire answers that confirm a diagnosis of alcohol use disorder, you might relieve the monotony (and tension) by asking something open-ended:

"That was a lot of questions. Now perhaps you could tell me how you plan to deal with your drinking in the future."

By combining styles, you can obtain detailed, structured information, as well as encourage your patient to generate important new material; the combination of styles should help you obtain material that has maximum validity.

SENSITIVITY TRAINING

It is important to remember that highly structured questioning needn't (and shouldn't) be abrasive or otherwise unpleasant. You can soften any question with a sympathetic facial expression or tone of voice. But you should also phrase your requests so as to help your patient talk about a variety of sensitive issues:

"I realize that your wife's death makes it hard for you to talk about her." (This comment acknowledges that the topic is important enough to pursue, despite the patient's obvious distress.)

"How do you think other people would deal with a daughter who's gotten into trouble with the law?" (By asking how others might react or feel, you may be able to reduce your patient's sense of personal involvement and responsibility. This particular expression also suggests that the patient is not alone in suffering from this sort of experience. The result could be information that you would otherwise miss.)

"What if the police picked you up for drinking—how would you feel?" (Using supposition, you can help your patient achieve some distance from an emotionally charged situation.)

"Have you ever had the opportunity to tell your wife you were sorry for hitting her?" (Here you soften the question by suggesting that chance might have prevented some praiseworthy action that your patient should have taken, but didn't.)

TRANSITIONS

Effective interviewing isn't just asking one question after another. You must also pay attention to the overall coherence of what you and the patient are saying. The sentence or phrase you use to get from one topic to the next is called a *transition*. Because it points the way to where you are going, a careful transition keeps the patient from feeling herded along your path. Transitions also help tie the entire story together.

The best transitions are couched in language that flows naturally, as in a conversation. Try to let each question take off from a portion of

the previous answer. Whenever possible, use the patient's own words as a vehicle for exploration:

PATIENT: . . . so our finances really changed for the better when my wife got a full-time job.

INTERVIEWER: And what about your relationship—did it change after your wife got a full-time job?

Interviews can't always proceed in a linear fashion. If you are discussing important topic *A* when *B* is mentioned, your interview could become scattered unless you get closure on *A* before moving on. Later, if you reintroduce *B* by referring to your patient's earlier statement, you will have made a smooth transition. For example:

"A few minutes ago you mentioned that the depression seems to get better when you drink alcohol. Could you tell me some more about the drinking?"

You can use any common factor—time, place, family relationships, a job—to smooth the flow of the conversation:

PATIENT: . . . so it was just after my brother left for Iraq that my mother died.

INTERVIEWER: And what were you doing at that time?

No one likes to be given the third degree; patients are no exception. You should therefore try to make your interview feel like a conversation, not an interrogation. Smooth transitions help to create that feeling. But when you have to make an abrupt transition, flag it so the patient realizes that you are changing gears intentionally:

"I think I've got a good picture of your drinking. Now I'd like to move on to something different. Could you tell me whether you've ever had problems with other substances, such as marijuana or cocaine?"

Once you and your patient have become accustomed to one another, you will probably find that a single word, appropriately emphasized, can signal a change of topics:

"*Now,* please tell me what happened when you and your husband were cooking and selling methamphetamine."

The one time you may feel tempted to make a fairly abrupt transition is if your patient becomes angry or anxious. Even then, you should

attempt to smooth the transition by acknowledging the shift—and the patient's right to whatever upset feelings you may have inadvertently elicited. For example:

> "I can see that it's pretty upsetting to talk about how your wife ran off with her lover. I don't blame you. It's an area we can easily skip for now. Instead, let me ask you some more about your new girlfriend."

And of course, if it is your patient who abruptly changes the subject, you should try to learn why.

CHAPTER 11

Mental Status Exam I: Behavioral Aspects

WHAT IS THE MENTAL STATUS EXAM?

The mental status exam (MSE) is simply your assessment of the patient's current mental functioning. Originally a part of the traditional neurological exam, now it is a staple of the initial mental health evaluation. This and the following chapter discuss the complete MSE. The amount and type of material presented here may seem daunting at first, but once learned, it becomes automatic and easy to cover in a few minutes.

The MSE is usually divided into several parts. They can be arranged in many different ways. Arrange your MSE any way you wish, as long as you cover all the parts. Your best bet is to choose a format, memorize it, and perform your MSE the same way every time until it has become second nature.

The following format has worked well for many professionals. It is based on the fact that the MSE includes two large areas: behavioral and cognitive.

Behavioral Aspects

To obtain the behavioral material, you don't have to ask special questions or perform tests. Mostly you just observe speech and behavior while you are talking with your patient (except in the area of mood, which requires a few questions). The behavioral aspects are as follows:

1. General appearance and behavior
2. Mood
3. Flow of thought

Cognitive Aspects

The cognitive portions of the MSE are concerned with what your patient is thinking (talking) about. Their evaluation demands more activity on your part. They include the following:

1. Content of thought
2. Perception
3. Cognition
4. Insight and judgment

The cognitive aspects will be described in Chapter 12.

I will define and explain the standard terms you need to know. *Italics* will indicate how you might interpret this information. However, remember these two facts: Many different interpretations may be possible, and isolated bits of even quite unusual behavior may be completely normal. Throughout your interview, you should be constantly evaluating what you observe of your patient's present behavior against what the history would lead you to expect.

GENERAL APPEARANCE AND BEHAVIOR

You can learn a great deal about a patient just by watching. Most of the following are characteristics that you should begin to notice first thing in your interview, even before anyone says a word.

Physical Characteristics

What is your patient's ethnicity? *Various studies suggest that Hispanic patients report symptoms differently from Anglos. Some diagnoses are more common among, for example, Native Americans. Any patient may have difficulty relating to a clinician of a different ethnicity.*

How old would you say this person is? Does apparent age jibe with stated age? *Age can suggest certain diagnoses. Eating disorders and schizophrenia are more likely in a young patient (late teens to mid-30s), whereas symptoms of depression with melancholia or Alzheimer's dementia are more common in older patients.*

Notice your patient's body build. Is it slender? Stocky? Muscular? What about posture? (Erect? Slumped?) Are walking and other movements graceful or jerky? Is there a limp? Are there unusual physical characteristics, such as scars, tattoos, or missing limbs? How would you assess the patient's general nutrition and body weight? (Obese? Slender? Wasted?) *Abnormal thinness suggests anorexia nervosa. Poor nutrition may not*

be related to mental disorder, but it can indicate a chronic debilitating physical disease, depression, substance misuse, or homelessness.

When you shake hands during your introductions, notice whether the patient's palms are dry or damp. Is the grip firm and hearty, or limp and halfhearted?

Alertness

Your patient's alertness can be graded along a continuum.

- *Full or normal alertness* implies awareness of the environment and the ability to respond quickly to a variety of sensory stimuli.
- *Drowsiness* and *clouding of consciousness* refer somewhat imprecisely to someone who is awake but less than fully alert. Drowsiness suggests that the patient can be stimulated to full wakefulness. Clouding of consciousness may be less transient, as in a person who has taken a drug overdose, and it implies the pathological impairment of most cognitive functions.
- *Coma* is a condition from which the patient cannot be aroused at all, even by stimuli such as deep pain or noxious odors.

Lying outside the continuum above is *stupor*—a poorly defined term that can mean unconsciousness, but may instead refer to a state in which the person, though apparently awake, doesn't move voluntarily or speak.

It isn't uncommon to encounter fluctuating consciousness during a single interview session. Carefully note any alterations in level of consciousness; they can affect your interpretation of tests, as well as your informal observations of the patient's behavior.

Some patients will appear *more* alert than is usually considered normal. These people may rapidly and repeatedly glance about the room, as if suspiciously scanning the environment for danger. *Such hypervigilance or hyperalertness is found in paranoid disorders, use of some substances (such as central nervous system stimulants and hallucinogens), and PTSD. However, states of heightened awareness can also be found in normal people (lovers, for example, and religious converts).*

Clothing and Hygiene

Is your patient's clothing clean and well cared for or dirty and tattered? Is it casual or formal? Contemporary or out of date? Is it appropriate to the climate and to the circumstances of your meeting? Notice any jewelry. *Bright colors may suggest mania; something as ordinary as a misbuttoned shirt or coat could indicate dementia. Bizarre dress, such as an adult wearing a Boy Scout uniform, suggests psychosis.*

What is your patient's hairstyle and hair color? Is there any facial hair? What about personal hygiene? *If the patient is disheveled or malodorous, suspect serious illness such as schizophrenia or a substance use disorder.*

Motor Activity

Try to assess dominant body attitude: Is it one of apparent relaxation, or does the patient sit tensely on the edge of the chair?

Notice the amount of motor activity. As you talk, does your patient sit quietly? Does this seem to approach immobility at times? *Reduced mobility is encountered in a variety of mental conditions and in frontal lobe brain dysfunction with various physical causes. Complete immobility is rare and can be a feature of profound depression or catatonia.*

Much more common in mental health patients is excessive motion. Does your patient fidget, jiggle a leg up and down, or frequently arise from the chair to pace? *These behaviors may be due to* akathisia, *a side effect of the older (and still used) type of antipsychotic drugs. Sometimes akathisia can become so severe that a patient literally cannot sit still and spends much time pacing restlessly around the room. Occasional uneasy shifting of position is more likely to be the consequence of simple anxiety, or sometimes of restless legs syndrome.*

Mostly, a patient's gestures will just express spoken feelings or emphasize verbalized statements ("talking with the hands"). Some gestures, however, convey unvoiced ideas—such as the circled OK of thumb and forefinger or the not-so-OK raised middle finger. Observe your patient's hands. Are they folded at rest, or are fists kept tightly clenched? Are fingernails dirty, bitten, stained, or carefully manicured? Is there a tremor? *This could be due to anxiety, but tremor of a pill-rolling type is often seen in Parkinson's disease and in pseudoparkinsonism (a frequent side effect of older antipsychotic drugs).*

Notice any behavior such as inappropriate scratching, touching, or rubbing in public. Does this person pick at skin or clothing? *A possible explanation is delirium, which can have a variety of physical or chemical causes. One type is delirium tremens (DTs), found in severe alcohol use disorder.*

It is extremely important, especially in chronically ill mental patients, to look for the involuntary movements of face and limbs associated with tardive dyskinesia. Are there any twisting or writhing movements of the extremities? What about chewing, facial grimacing, puckering of lips, or protrusions of the tongue? These movements may be gross and unmistakable, but more often they will be mild and may be hard to identify. If in doubt, ask to see your patient's tongue; worm-like fasciculations may be the only early sign of tardive dyskinesia.

You may notice other unusual behaviors. Look for any *mannerisms*—unnecessary behaviors that are part of a goal-directed activity. (An

example would be the flourish that some people make with a pen before writing something.) *Mannerisms are common and normal; to some degree, we all have them.* On the other hand, *stereotypies* are behaviors that are not goal-directed. An example would be a patient who repeatedly and to no apparent purpose pauses to make the peace sign. *Posturing* is identified when a patient strikes and holds a pose (such as a Napoleonic hand tucked inside a shirt front) that has no apparent purpose. Purposeless *negativism* may be shown by persistent silence or by turning away from the examiner. In *waxy flexibility*, you can move the patient's rigidly held limbs only slowly and with steady force, as though you were bending a rod made of soft wax. Patients with *catalepsy* will maintain any odd or unusual posture you place them in, despite the fact that you urge them to relax. *Stereotypies, posturing, waxy flexibility, negativism, and catalepsy are infrequently encountered today, and then only in the most seriously ill of hospitalized patients. They usually signify psychosis–frequently schizophrenia.*

Facial Expression

Are there any tics of eyes, mouth, or other body parts? Does the patient smile and generally show normal mobility of facial expression? *A fixed, motionless expression could indicate senility, the rigidity common in Parkinson's disease, or pseudoparkinsonism from antipsychotic drugs.* How well does this patient make eye contact with you? *A psychotic patient may stare fixedly at you; in depression, the gaze may seem stuck to the floor.* As you converse, does your patient repeatedly glance around the room, as though noticing something you cannot see or attending to voices no one else can hear? *These apparent responses to an internal stimulus may be encountered in patients who have psychoses of various types.*

You should watch for any other behaviors that contradict the information your patient is giving you verbally:

> You notice the motor restlessness of akathisia, when your patient denies taking antipsychotic medication.
>
> Your patient has a sad face and seems about to cry, but claims to feel cheerful.

Voice

As you converse, notice the volume, pitch, and clarity of the patient's voice. Does it have a normal lilt (called *prosody*), or is it monotonous and dull? From the use of grammar, can you tell anything about education or family background? Does an accent identify the country or region in which the patient was reared? Does the patient stutter, lisp, mumble, or demonstrate some other speech impediment? Are there mannerisms of

speech, such as words or phrases that are used habitually? How would you characterize the tone of voice: friendly, angry, bored, sad?

Attitude toward Examiner

There are several continuums along which you could describe your patient's apparent relationship to you:

Cooperative → obstructionistic
Friendly → hostile
Open → secretive
Involved → apathetic

How far to the left your patient scores on each of these factors will help determine the amount of information you can expect to obtain during the interview, as well as the strength of your rapport. In addition, note any evidence of seductiveness or evasiveness.

MOOD

The terms *mood* and *affect* have been variously defined. Nowadays, some clinicians use them interchangeably. I will use *mood* to mean the way a person claims to be feeling, and *affect* to mean how the person appears to be feeling. Therefore, the term *affect* signifies not only stated mood, but facial expression, posture, eye contact (or its lack), and tearfulness as well.

Mood (or affect) is described in several dimensions: type, lability, appropriateness, and (by some observers) intensity.

Type

What is the patient's type of mood? This means simply the basic quality of mood. In Chapter 7 I have presented some 60 expressions of feeling (see Table 7.1), but they can be boiled down to just a few basic moods. Trouble is, there isn't a lot of agreement as to exactly what's basic. Here's my take on the best consensus judgment of a dozen or more experts on basic emotions:

Anger
Anxiety
Contempt
Disgust
Fear
Guilt
Joy
Love
Sadness
Shame
Surprise

One mood will usually predominate. When it doesn't, *normal* or *about medium* serves as an adequate description.

Your patient's mood will probably be obvious from what you have already observed. If not, ask:

"How are you feeling now?"

"What is your mood at this time?"

If you detect sadness, you might inquire:

"Do you feel like crying?"

An occasional patient will burst into tears—a response that can be distressing for a beginning interviewer, but is sometimes therapeutic for the patient. Have some facial tissues available for this situation, and try to learn what feelings lie behind the cloudburst.

You can also infer a good deal from your patient's body language. Here are a few nonverbal cues to feelings:

Anger: clenched jaw, knotted fists, flushing of face or neck, drumming fingers, extended neck veins, fixed stare

Anxiety: jiggling foot, twisting fingers, affected casualness (such as toothpicking)

Sadness: moistening of eyes, drooping shoulders, slowed movements

Shame: poor eye contact, blushing, shrugging

Some patients have difficulty describing, or even recognizing, how they feel. A few cannot seem to do it at all. I'll mention again the term *alexithymia*, which is sometimes used to describe the inability to recognize or describe one's own feelings.

Lability

Even normal people will sometimes show two or more moods within a brief time span. For example, at a funny yet tender moment in a movie or play, anyone might laugh and weep almost simultaneously. But wide swings of mood are often abnormal and should be watched for in a mental health interview. Such mood swings are termed *increased lability* of mood. *Some patients with personality disorders may show dramatic swings of mood from ecstasy to tears, all within a matter of minutes. A patient with manic euphoria may suddenly burst into bitter tears, then rapidly return to bubbling high spirits (the term* microdepression *is sometimes used to describe this phenomenon). In*

the cognitive disorders, rapid mood swings can be so severe as to earn the term affective incontinence.

The opposite picture occurs when the patient shows reduced variation of mood. This lack of response to environmental stimuli is called *flattening* of mood. The term *blunting* has been used as a synonym, although some writers use *flattening* to mean a compressed range of mood and reserve *blunting* for a lack of emotional sensitivity. *However the terms are defined, these patients seem unable to relate to other people's emotions. Though classically identified as indicating schizophrenia, relative immobility of mood is also found in severe depression and in Parkinson's disease and other neurological conditions.* Blandness *of affect, in which nothing much ever seems to ruffle the patient, classically occurs in dementia.*

Appropriateness

Appropriateness of mood is your estimate of how well the patient's mood matches the situation and the content of thought. Your judgment will be affected by two cultures: your own and the patient's. Although most people show inappropriate emotional reactions from time to time, a pronounced inappropriateness may suggest certain diagnostic groups. *A person who giggles or laughs while, for example, describing something sad (such as the death of a close relative) may be suffering from schizophrenia*. Pathological affect *(either inappropriate laughing or weeping) may be encountered in pseudobulbar palsy, which can have a variety of causes, including multiple sclerosis and strokes. Patients with DSM-5 somatic symptom disorders (DSM-IV somatoform disorders) will sometimes talk about their physical complaints, such as paralysis or blindness, with a nonchalance more appropriate to a weather report. This special type of inappropriate mood is called* la belle indifférénce *(French for "lofty indifference").*

Although you should be continually alert for these and other signs of otherwise unexpressed feeling, it is important not to overinterpret. Try instead to relate what you observe to what you hear and to what you yourself might feel under similar circumstances. Are tears warranted by the topic being discussed, or does your patient appear to be unnaturally sad? Does the smile seem genuine, or is it forced, perhaps hiding other feelings?

Intensity

Although the designation is subjective and therefore somewhat arbitrary, you can grade intensity of mood as mild, moderate, or severe (think of the progression from dysthymia through major depression without and with psychosis). You might also want to note the reactivity of a mood: Is it fleeting, prolonged, or somewhere in between?

FLOW OF THOUGHT

The term *flow of thought* is a slight misnomer. What we are interested in is the thought, but what we actually perceive is the flow of speech. We assume that the speech we hear reflects the patient's thoughts.

Most of the problems described here are usually apparent only during the acute phase of illness. They can be grouped into two overall categories: (1) defects of association (the way words are joined together to make phrases and sentences), and (2) abnormal rate and rhythm.

Unhappily, mental health clinicians don't always agree about these definitions, so I've tried to adopt a consensus view. However, you will be safest if you record in quotes actual examples of your patient's speech. This will remind you later exactly what the patient said, will help anyone who reads your write-up to understand what you mean by the terms you use, and will provide a recorded basis for judging future change in thought patterns that may occur with treatment.

Be careful not to attribute undue pathological significance to your patient's manner of speaking. Speech patterns different from yours can be shaped by neurological or other medical disorders, by cultural and educational influences, or by growing up speaking a different primary language.

Association

First, notice whether speech is spontaneous or occurs only in response to questions. If the latter, you should take some pains to induce the patient to talk spontaneously:

> "I'm grateful for all the answers you've given me. But now I think it would help if you'll just talk for a while about your problems. That way, I'll get a better feeling for what is bothering you."

If you don't succeed with this, the amount of information you can obtain about speech patterns will obviously be somewhat limited. Record examples of what speech there is, and note the attempts you made to obtain more.

• *Derailment*. Sometimes called *loose associations*, derailment is a breakdown of thought association in which one idea seems to run into another. The two ideas may be related in a tenuous way or not related at all. You can understand the sequence of words, but their general direction seems to be governed not by logic but by rhymes, puns, or other rules that might not be apparent to an observer. What comes out is speech that seems to mean something to the patient but not to you:

"She tells me something in one morning and out the other."

"Half a loaf is better than the whole enchilada."

"I'll never go back to that store again. I don't have enough sand for my shoes."

• A special type of loose association is *flight of ideas*, in which a word or phrase from one thought stimulates the patient to take off in another direction. Although the patient (and you) might be able to define the relationship between two consecutive ideas, the entire thought process appears to have no ultimate goal, and the patient will usually lose the thread of the original question.

INTERVIEWER: When did you enter the hospital?

PATIENT: I came in on a Monday. Monday is wash day. That's what I'm gonna do—wash that man right outta my hair. He's the tortoise and I'm the hare.

Patients with mania often have flight of ideas associated with push of speech (described later in this chapter).

• *Tangentiality (tangential speech)*. These terms describe an answer that seems irrelevant to the question asked. If there is some relationship between question and answer, it is hard to discern.

INTERVIEWER: How long did you live in Wichita?

PATIENT: Even anteaters like to French-kiss.

Derailments and tangentiality are classically encountered in psychosis, often schizophrenia, but patients with mania can also exhibit these symptoms.

• *Poverty of speech*. This is a marked reduction from normal in the amount of spontaneous speech. The patient answers briefly when you expect elaboration and, unless prompted, may say nothing for long periods. When this behavior is carried to the extreme of muteness, there is little or no speech at all. *Patients with depression may show poverty of speech. Muteness is more characteristic of schizophrenia, but it is sometimes found in somatic symptom disorders. It must be distinguished from* aphonia *of neurological origin.*

The following terms designate speech abnormalities that are seldom found in clinical interviews. I will define them briefly, but unless you work on the back ward of a large psychiatric hospital, you may never encounter any of these behaviors. Most occur classically in schizophrenia, but any may be found in psychoses of neurocognitive origin. When you do encounter an example, be sure to record it and try to learn why the patient has responded that way.

• *Thought blocking*. The train of thought stops suddenly, before it arrives at the station. The patient can usually give no explanation more adequate than that the thought has been "forgotten."

• *Alliteration*. A phrase or sentence intentionally contains multiple repetitions of the same or similar sounds: "I ran the risk, Doctor dear, of recognizing revolting rabbits racing in the roadster."

• *Clang associations*. The choice of individual words is governed by rhyming or other similarity of sound, not by the requirements of communication.

INTERVIEWER: Who brought you to the hospital?

PATIENT: My wife, she's the wife of my life, no strife.

• *Echolalia*. In answering a question, the patient unnecessarily repeats words or phrases of the interviewer. This can be fairly subtle, to the point that you may recognize it only after several repetitions.

INTERVIEWER: How long were you in the hospital that time?

PATIENT: How long were you in the hospital? I was in the hospital a long, long time, that's how long I was in the hospital.

• *Verbigeration*. The patient continues to repeat a word or phrase without obvious purpose: "It was deathly still. Deathly. Deathly still. Deathly. Still deathly."

• *Incoherence*. Speech is so disorganized that even individual words or phrases appear to have no logical connection: " A bery heavy burtation tonight, we had a very dareson bite let's go head . . . " (In this case, reporter Serene Branson knew she was talking nonsense on live TV in 2011. Although she was at first thought to be having a stroke, it turned out to be the aura of a migraine.) Sometimes incoherence is more colorfully termed *word salad*.

• *Neologisms*. In the absence of artistic intent (such as in Lewis Carroll's "Jabberwocky"—"'Twas brillig, and the slithy toves/Did gyre and gimble in the wabe . . .")—the patient makes up words, often from parts of dictionary words. The resulting structure may sound quite authentic: "I didn't want him spinning cobwebs all over, so I hit him with my arachnosquisher [a shoe]."

• *Perseveration*. The patient repeats words or phrases, or repeatedly returns to a point that has already been covered or mentioned.

INTERVIEWER: And what was your girlfriend like?

PATIENT: Oh, she had long blonde hair and she wore it in a ponytail.

INTERVIEWER: Did you feel she supported you when you had that trouble with your ex-wife?

PATIENT: But she wasn't very tall. Just a bit over 5 feet.

INTERVIEWER: What I'd really like is to hear about your relationship with her.

PATIENT: She was pretty, really pretty.

Perseveration, which can also occur as repeated motor behavior, usually occurs in the context of a memory defect and indicates organic disease involving the brain.

- *Stilted speech*. Accent, phraseology, or choice of words gives speech an unnatural or quaint flavor, as if the patient were someone else entirely. An American who affects a British accent or who frequently uses British idioms might be said to have stilted speech.

Rate and Rhythm of Speech

Patients who speak rapidly, and often at considerable length, are said to show *push of speech* (or *pressured speech*). Because these patients are often loud and hard to interrupt, they can pose a real challenge for interviewers. Push of speech is usually associated with *decreased latency of response*, in which the period of time between your question and the patient's response is markedly reduced. Sometimes the response seems to come almost before you have asked your question. *Push of speech and decreased latency of response are classically found in patients with mania, who may tell you that their words cannot keep up with their rapid thoughts.*

On the other hand, a patient with *increased latency of response* takes far longer than normal to answer or interjects long pauses between sentences. When the statement is finally offered, it may be brief and delivered with excruciating slowness. *Often reflecting more general psychomotor slowing, increased latency of response can be found in severe depression and neurological disorders.*

When the timing of syllables deviates from normal, disorders of speech rhythm occur. *Stuttering* is one such disorder. In *cluttering*, the patient speaks rapidly and becomes tangle-tongued and disorganized. Patients with cerebellar lesions may utter each syllable at the same pace as the last, yielding a rate that is too precisely even. Those with some forms of muscular dystrophy may speak in clusters or have difficulty uttering syllables.

Other speech patterns occur that usually have no pathological significance at all. Whereas they may be quite noticeable to the listener, the individual who uses them can remain totally unaware of how often they occur.

The term *circumstantial speech* means that much extraneous material is included with the principal message. In this common speech pattern, the speaker eventually comes to the point, although often at considerable cost to the listener's time and patience.

In *distractible speech*, the speaker's attention is diverted by stimuli that are extraneous to the conversation. Noise in the corridor or a moth fluttering against a window may send the conversation off in a new (though usually temporary) direction. Distractible speech is usually normal, but you may encounter it in a patient with mania.

Verbal tics are conventional expressions that many people overuse from time to time, usually without realizing it. Such time fillers are almost always normal, if boring.

"You know"

"I go" (for "I said")

"Basically"

"Really"

"Awesome"

Many of the terms we use to label speech patterns are confusing, and various experts will use them differently. Once again, I strongly recommend that you make your record as clear as possible by writing down verbatim examples of any speech you consider to be pathological.

CHAPTER 12

Mental Status Exam II: Cognitive Aspects

Nearly all of the findings mentioned in Chapter 11 are typically made by passive observation alone. In contrast, you must use active questioning to elicit most of the material presented in this chapter.

SHOULD YOU DO A FORMAL MENTAL STATUS EXAM?

Some clinicians still fail to assess—or to report—the cognitive aspects of the MSE, despite the critical importance of this information to the overall evaluation of any patient. Others feel it's insulting to ask a well-functioning adult obvious, routine questions: "What is the date?" or "Who is the president?" They choose not to do formal testing without a positive indication, such as a complaint by relatives that the patient has seemed forgetful.

In most cases, you probably wouldn't jump right in and ask about hearing voices. But unless you ask eventually, you can never be sure that any patient is unimpaired. This is why I strongly recommend, especially if you are just starting out, that you do a formal MSE on all patients. You can take some steps to reduce the likelihood of resentment for the patient and embarrassment for you.

- Start by explaining what you are about to do. Stress the fact that these questions are the norm and are not occasioned by something the patient has said or done:

  "Now I'd like to ask some routine questions that will help me assess how you think about things. It will only take a few minutes."

Words such as *routine* and *normal* help pull the sting from questions that might otherwise be taken amiss.

- Use whatever degree of positive feedback seems warranted, as long as you speak no more than the truth:

  "That's excellent! This is the best I've seen anyone do calculations all week."

- Respond attentively to any distress these questions seem to cause. If necessary, take a break and return later to any aspect that is troublesome:

  "Subtracting sevens in your head is tough. Let's give it a rest and try presidents instead."

- In any case, it's a good idea to get this portion of your evaluation out of the way during your first interview. If you delay asking until treatment is well underway, you increase the possibility of embarrassment for you and your patient.

Anyone who observes seasoned professionals doing the formal portions of the MSE will notice that they don't ask every question of every patient. With time and experience, clinicians learn which tests can be omitted for certain patients and which must be performed every time. While you are still learning, I recommend that you do the entire procedure each time, without exception. That way you will learn it all; you will also develop your own sense of what responses are normal for each test. Once you're experienced (after your first several hundred exams), you can decide which tests to omit and when.

The MSE properly concerns only current behaviors, experiences, and emotions. However, it is often convenient to cover related historical data at the same time. This is the reason why so many of the screening questions begin with "Have you *ever* . . . "

One further thought: Some of the experiences covered in the following pages are unusual enough that your patient might feel reluctant to respond frankly. To address such reluctance, you can point out that people can have all types of strange experiences when they are stressed or ill or taking medications. Framing your inquiry this way can help reduce anxiety and encourage your patient to reveal what you need to know.

CONTENT OF THOUGHT

Whatever the speaker is focused on at the moment constitutes the *content of thought*. During the history of the present illness, this will usually concern the problems that caused the patient to seek treatment.

However, there are several items of thought content that you must cover with every exam you do. The patient may spontaneously mention some of these , but mostly these major thought abnormalities will require screening questions.

Whenever you are investigating abnormalities of thought, probe gently enough that the patient continues to view you as someone who is sympathetic and friendly. Don't make snap judgments, and try not to show surprise at the responses you hear. Remember that bizarre ideas such as flying saucers or talking fish may seem as normal to the patient as do your own closest-held convictions (even including religion and politics) to you.

Delusions

A *delusion* is a fixed, false belief that the patient's culture and education cannot account for. All portions of this definition must be fulfilled. Others of the same culture must consider the belief or idea to be obviously false; it must be unshakable, despite evidence that it is wrong.

"I've been sent to guard the president." At age 73, this patient had chronic alcoholism and hadn't worked in years.

"My husband goes secretly to have sex with the woman across the street. He signals her with the venetian blinds." With a sigh, her husband volunteered that he had been impotent since his prostate operation.

"My initials are J. C. That means I'm Jesus Christ!" Six brothers and sisters testified that he had been ill for years.

You can test the strength of your patient's beliefs by asking:

"Is it possible that this feeling is due to some sort of nervous or emotional problem?"

If the patient replies, "No," and perhaps claims instead that the hospital staff has just joined the conspiracy, score the idea as delusional.

Some patients, when similarly challenged, will agree that another explanation is possible; for them, you would not diagnose a delusion.

"It only seemed as if there was some sort of plot."

"Perhaps it was imaginary, after all!"

"My nerves have been bad lately."

Call it a delusion only when the patient maintains an obviously false explanation despite clear evidence to the contrary.

Because the cultural/educational criterion must also be satisfied, a traditional Navajo should not be called delusional for believing in witches, nor should children who write letters to Santa Claus.

Screen for delusions by asking questions such as the following (with appropriate pauses for responses):

"Have you ever had any thoughts or feelings that people were spying on you, talking about you, or trying to harm you in some way?"

"Have you ever gotten unusual messages?"

"Have you ever had any other thoughts or ideas that others might consider unusual?"

Because they are so improbable, you can easily determine that some claims are false (such as the prototypical bizarre delusion of being abducted in a rocket ship by space aliens). Others carry a whiff of plausibility that should make you consider, "Could this story actually be true?" I've had this sort of reflection when confronted by patients who have told me of efforts to avoid pursuit by ex-spouses or lawsuits from former business partners. Occasionally in-laws really *are* trying to break up a marriage. Although such narratives sometimes crumple under the pressure of internal inconsistency, you may need third-party verification to determine where the truth lies.

Patients often realize that other people think their delusional ideas are unusual or strange; they may go to some lengths to hide these delusions. Usually a sympathetic, interested, nonjudgmental manner will relax tension enough for a free discussion of these problems. You may be able to get your patient to elaborate on a delusion, perhaps to volunteer others by asking the noncommittal question:

"How do you know that this [the delusion] is the case?"

You may have to walk a fine line: If you challenge delusions, you could upset the patient; if you accept them, you risk further confirming false ideas in the patient's mind. You'll be safer to show neither disbelief nor credulity, if indeed you can avoid stating any opinion at all. If pressed for your view, you can truthfully say:

"Many people would consider it [the delusion] unusual."

Because this is something the patient already realizes, it comes as no shock; the answer often seems to satisfy. If further pressed, you may have to respond more fully:

> "I think that other explanations might be able to account for your discomfort. You could be mistaken, or it might be some form of nervousness."

Because you offer it tentatively, this sort of statement might not provoke much argument. If it does, perhaps you and the patient can amicably agree to disagree.

Once you have detected a delusion, learn all you can about it—especially, the extent to which it affects different aspects of the patient's life. The following questions should help:

> "How long have you felt this way?"
>
> "What actions have you taken as a result?"
>
> "What other actions do you plan to take?"
>
> "How do you feel about [these beliefs]?"
>
> "Why do you think this is happening?"

More specific "Why . . ." questions—"Why do you think you were fired?"—are another way that you may be able to elicit delusions.

Finally, is the delusion *mood-congruent*? In other words, is the content of the delusion in keeping with the patient's mood? Here is an example of a mood-congruent delusion:

> A middle-aged man hospitalized for a depression believed that he had literally gone to hell. He thought that the medical personnel clustered around his bedside were devils who had gathered to administer well-deserved punishment for his sins.

And an example of a mood-incongruent delusion:

> An elderly woman, for many years chronically ill with psychosis, also had ankle swelling due to heart failure. She rather blandly explained that her body fluids were being pulled into her legs by gravity machines installed in her basement by Nazis.

The presence of mood-congruent delusions should make you suspect a mood disorder; mood-incongruent delusions are more typical of schizophrenia.

Delusion Types

In the course of interviewing many patients, you will probably encounter a wide variety of delusions. Here are some of the best known:

• Death. Also called *nihilistic* delusions, these rare symptoms are extreme cases of delusions of ill health.

• Grandeur. The false belief is that the patient is someone of exalted station (God, Beyoncé) or has powers or gifts not possessed by other people (immense wealth, virtuoso musical ability, eternal life). Be sure to distinguish these ideas from joking references: Presidents, kings, and captains of industry sometimes assume the mantle of prescience or invincibility. To them, "I am God" may be a partly realized figure of speech that doesn't signify mental pathology. *Delusions of grandeur are typically found in mania, but may also occur in schizophrenia.*

• Guilt. These patients believe they have committed some grave error or sin, for which they may claim to deserve punishment. *Delusions of guilt are found especially in severe depression and in delusional disorder.*

• Ill health or bodily change. These patients believe they are afflicted by some terrible disease: Their insides have rotted; their bowels have turned to cement. *Delusions of ill health and somatic delusions are occasionally found in severe depression or schizophrenia.*

• Jealousy. The patient's spouse or partner "has been unfaithful." *Delusional jealousy is classically seen in alcoholic paranoia, but is also encountered in schizophrenia and delusional disorder. It can lead to spousal abuse and even domestic homicide.*

• Misidentification. The patient believes that someone, usually a close relative, has been replaced by an exact double (this belief is known as Capgras syndrome), or that a stranger is actually someone the patient knows. *Such delusional perceptions are often rooted in brain pathology, though they are also found in patients with schizophrenia.*

• Passivity or influence. Such patients believe that they are being controlled in unusual ways by outside influences, such as television, radio, or microwaves. As a result, they can deny responsibility for their behavior. By contrast, some may feel that they can control the environment: What they have for breakfast has influenced the secretary of state to mention Iran in a speech, or their thought waves cause rivers to rise. *Such delusions suggest schizophrenia.*

• Persecution. Patients believe that they are being threatened, ridiculed, discriminated against, or otherwise interfered with. *These are typically found in schizophrenia.*

• Poverty. Despite evidence to the contrary (money in the bank, a regular disability check), these patients believe that destitution will force them to sell the house and auction their property. *These delusions sometimes occur in severe depression.*

• Reference. People are spying upon patients, slandering them, or working against them in some other way. These patients "observe" that people whisper about them as they walk past; print or broadcast media contain messages that are intended specifically for them. For example, "On *The NewsHour* last night, Judy Woodruff said that a settlement was imminent. This means that I should agree to the property settlement with my former wife." *Delusions of reference are especially common in schizophrenia, but may be found in other psychoses as well.*

• Thought broadcasting. The patient's thoughts seem to be transmitted locally or across the continent. *Thought broadcasting is found in schizophrenia.*

• Thought control. Thoughts, feelings, or ideas are put into the patient's mind or are withdrawn from it. *Closely related to passivity feelings, these delusions have similar import.*

PERCEPTION

Hallucinations

Hallucinations are false sensory perceptions that occur in the absence of a related sensory stimulus. For example, the patient hears voices speaking from a vacant closet or sees purple snakes floating in the clear bathwater. Hallucinations are typically experienced as occurring in real space (that is, *not* imagined, as in the mind's eye) and can involve any of the five senses. Among mental health patients, auditory hallucinations are by far the most common; visual hallucinations are next.

Screen for hallucinations by asking:

"Do you ever hear voices or other sounds when there is no one around to produce them?"

"Do you ever see things other people cannot see?"

Some patients mistakenly respond "Yes" to questions about auditory hallucinations, when they mean only that they hear a voice right now (the interviewer's) or that they "hear" their own thoughts—though not spoken aloud as in audible thoughts, which I've described below. With careful questioning, you can usually distinguish these false positives from genuine hallucinations.

For example, when someone claims to hear noises or spoken words, ask:

"Could this be something coming from you, like your conscience or your own thoughts?"

An admission that it could be "my imagination" or "sounds from out in the hall" doesn't fit with the sort of true auditory hallucination I expect from a person who has a serious psychosis. I'll sometimes ask a patient whether the voice is "as clear as mine is now," and whether it speaks in complete sentences, again discounting the seriousness of "no" answers. However, even some patients with schizophrenia report that their auditory hallucinations seem more like inner thoughts than like actual, external voices. Hallucinations that occur only when a patient is reliving trauma also suggest something other than schizophrenia—PTSD, perhaps. I may reassure such a patient that this sort of experience is not likely to mean actual psychosis.

Hallucinations should be characterized as to severity. *Auditory hallucinations*, for example, can be located on a continuum: Vague noises → mumbling → understandable words → phrases → complete sentences.

Here are some additional questions that can help you learn more about auditory hallucinations:

"How often do you hear this sort of voice?"

"Is it as clear as my voice is now?"

"Where is it coming from?" (The patient's head or body? The microwave oven? The hallway?)

"Whose voice is it?"

"Is there more than one?"

"Do they talk about you?"

"What do they say?"

"Do they hold conversations with one another?"

"What do you think the cause is?"

"Can other people hear these voices?"

"How do you react?" (Many patients are frightened by their hallucinations; some are only bemused.)

"Do the voices order you to do things?" (If so, does the patient obey them?) *This is an important point: Patients will sometimes obey command hallucinations, and have been known to inflict harm on other people as a result.*

Audible thoughts constitute a special form of auditory hallucination, in which patients hear their own thoughts spoken so loudly that others can hear them. *Audible thoughts, voices that make a running commentary on the patient's actions, and multiple voices talking to one another especially suggest schizophrenia.*

Visual hallucinations can also be graded: Points of light → blurred images → formed people (what size?) → scenes or tableaus. Some of the questions recommended for auditory hallucinations, appropriately modified, should be asked of patients who admit to visual hallucinations. You especially want to know when they occur (only when the patient is using drugs or alcohol, or at other times?) and what the content is. How does the patient respond to these hallucinations? (It can be extremely frightening to perceive faces changing color or form; one woman looked into the mirror and saw that she had become a mushroom!)

Visual hallucinations are especially characteristic of psychoses that occur with substance use or general medical conditions. For example, small animals or Lilliputian people are commonly reported by patients who experience DTs when withdrawing from heavy, prolonged alcohol use. Trailing phenomena, *in which images appear to linger on the patient's retina, sometimes accompany psychedelic drug use. Although most of the visual phenomena that occur in schizophrenia are illusions or transformations of actual stimuli (such as intensification of color, changes in the size of objects), patients with schizophrenia sometimes experience true visual hallucinations, too.*

Tactile (touch), *olfactory* (smell), and *gustatory* (taste) hallucinations are uncommon in mental health patients. *These symptoms usually suggest psychosis due to such disorders as brain tumor, toxicity, or a seizure disorder, though hallucinations of body sensation sometimes occur in schizophrenia. Visual, auditory, and tactile experiences may also occur in normal people when they are falling asleep or awakening. They are easily discerned from actual hallucinations by their exclusive time of occurrence.*

> A woman once told me, "You're going to think I'm crazy. Early one morning last year, I saw the Devil standing over me in my bed. I was completely paralyzed—I couldn't move my arms or legs, but I was totally awake! I was so frightened, I shook for an hour afterwards." It pleased me to tell her that she was sane—that she had experienced a combination of *hypnopompic imagery* (experiences, which can instead be auditory or tactile, that occur upon awakening) with sleep paralysis, which also sometimes occurs when awakening.

One of the joys of mental health practice is being able to offer the reassurance that someone's experience is within the normal range.

Anxiety Symptoms

Anxiety is fear that's neither directed at nor caused by anything specific the patient can identify. It is usually accompanied by various unpleasant bodily sensations. Other mental symptoms may include irritability, poor concentration, mental tension, worrying, and an exaggerated startle response.

Screen for anxiety symptoms by asking:

"Do you think you worry about things excessively or out of proportion to their real danger to you?"

"Does your family tell you that you're a worry-wart?"

"Do you feel anxious or tense much of the time?"

If any answer is "Yes," follow up with some of the questions covered in the section on anxiety in Chapter 13.

A *panic attack* is a discrete episode during which a patient suddenly experiences intense anxiety with bodily sensations such as rapid heartbeat, shortness of breath, tremor, and sweating—plus a long list of other possible physical symptoms. Patients often report fearing disaster, madness, or impending death. The episode usually peaks within a few minutes and wanes within half an hour.

Screen for panic attacks by asking:

"Have you ever had a panic attack—a time when you suddenly felt overwhelmingly frightened or anxious?"

Follow up with the same sort of questions you would ask for other anxiety disorders (Chapter 13 and Appendix D). *Complaints of inner tension, sometimes accompanied by marked restlessness, are typical of akathisia, found in patients who have used antipsychotic medications.*

Phobias

A *phobia* is an unreasonable and intense fear associated with some object or situation. Common *specific phobias* are fears of various animals, air travel, heights (*acrophobia*), and being closed in (*claustrophobia*). Common types of *social phobia* (now called *social anxiety disorder* in DSM-5) include fears of public speaking, eating in public, using a public urinal, or writing when others might see the patient's hand tremble. *Agoraphobia* is fear of being away from home or of being in public places.

Some might think that a phobia seems every bit as unreasonable as a delusion. The difference is that whereas the phobic patient recognizes how unreasonable these feelings are, the delusional patient does not.

Screen for phobias by asking:

"Have you ever had fears that seemed unreasonable or out of proportion to you, but that you just couldn't shake?"

"Have you ever been afraid of leaving home alone, or being in crowds, or in public places such as stores or on bridges?"

In the case of social anxiety, such as a fear of public speaking, be sure to ask about the development of anticipatory anxiety. In this condition, anxiety that is often intense and incapacitating occurs prior to performing the act that the patient dreads.

Dysmorphophobia is a term that's been used to describe excessive concern about slight (or imagined) defects in body appearance. Usually these flaws are facial (wrinkles, shape of nose), but they have been reported for nearly every imaginable body part. Of course, the patient cannot avoid the body part in question, so the condition is not really a phobia at all. It is now called *body dysmorphic disorder* and, in DSM-5, is classified with obsessions and compulsions.

Obsessions and Compulsions

An *obsession* is a belief, idea, or thought that dominates the patient's thought content and persists, despite the fact that the patient recognizes its unreality and may try to resist it. For example, a middle-aged man had the persistent thought of doing something embarrassing, such as standing up and screaming during a church service. Obsessions often involve dirt, time, or money.

Compulsions are acts performed repeatedly in a way that the patient realizes is neither useful nor appropriate. Often they are performed in response to (or to cope with) an obsession. Some examples:

Counting things repeatedly

Heeding groundless superstitions

Following rituals (such as a set bedtime routine that, if not followed to the letter, must be started all over again)

A key aspect of obsessions and compulsions is the fact that the patient usually realizes these ideas or behaviors are senseless and often tries to resist them.

Screen for obsessions and compulsions by asking:

"Have you ever had obsessional thoughts or ideas? I mean, thoughts that may seem senseless to you, but keep coming back anyway?"

"Have you ever had compulsions, such as rituals or routines that you feel you must perform over and over, even though you try to resist?" (Be ready to cite examples, should the patient ask.)

Some people do not realize that their behaviors—excessive neatness, for example—are at all unusual. Careful questioning may be required to draw them out:

"How tidy is your home? Your personal belongings?"

"Have you ever gone to bed and left dirty dishes in the sink?"

"If someone sits on your bed after you've made it, do you feel the need to straighten it again?"

A minor degree of obsessional thinking is quite common, so it's important to judge severity. As with phobias, this is best measured in terms of the effects on activities such as school, work, and family life. In severe cases, patients may spend many hours a day occupied in pointless handwashing, dressing, or bathroom rituals. As with phobias, ask about onset, duration, and treatment, as well as severity.

Thoughts of Violence

Whether or not there have been previous suicide attempts or violence directed at others, you must learn what the patient is thinking now. Screen for *suicidal ideas* by asking:

"Have you any ideas or thoughts of harming yourself in any way or of killing yourself?"

Because most of us have had such a thought at one time or another, a positive answer could reflect merely a fleeting reaction to stress or an overwhelming life situation. But it would be an unwarranted, potentially tragic leap of faith to ignore any answer that is even equivocal. You must thoroughly investigate any such ideas you uncover.

Review all the material you have already obtained about past suicide attempts (see Chapter 9). Learn whether the patient has current plans and the means to carry them out. You should ask:

"What would it take to make suicide seems less attractive?"

Regard as serious and ominous any equivalent to the answer "Nothing could." If you encounter this sort of thinking, especially if it is bolstered with evidence of current drinking or depression (feelings of worthlessness, hopelessness, trouble with thinking, loss of energy, guilt feelings), you may be facing a situation that demands hospitalization—possibly even before the hour is up.

Ideas of homicide or other violence present a similar urgent call to action. The terror of violent ideas is mitigated only by the fact that they are encountered much less frequently than are suicidal ideas. Screen for thoughts of homicide or violence toward others by asking:

"Have you ever felt so angry or upset that you thought about harming someone else?"

"Have you ever had trouble resisting the urge?"

Any positive answer must be followed up immediately and compared with the historical information you have already obtained. Are there plans or only ideas? Does your patient have the means (firearms, lethal drugs) to carry out this plan? Is there a timetable? A threat is more likely to be carried out if made against a specific person, especially an intimate partner, and if made face-to-face. However, I caution you to regard seriously any threat at all. (Be sure to review the detailed material on violence covered in Chapter 9.)

Experiences That Can Be Worrisome, but Are Usually Normal

There are a few experiences* you don't ordinarily have to ask about: Either they are normal or they have no diagnostic import. However, like my lady with the hypnopompic imagery on page 144, patients sometimes worry about them and bring them up during interview sessions. You should have explanations ready.

Illusions are misinterpretations of actual sensory stimuli. Usually visual, they most often occur when there is decreased sensory input (such as in dim light). Their benign nature is readily acknowledged as soon as the patient becomes aware of the mistake. You've probably had the experience yourself: A crack on the wall looks like a frightening snake; once you put on the light, you feel immediate relief. To distinguish illusions from hallucinations, obtain details about such matters as environmental circumstances and timing (perhaps only when going to sleep). Although usually normal, illusions can be encountered in patients with dementia or delirium.

Déjà vu, French for "already seen," is the commonplace sensation that a person has previously experienced a situation or locale when that is probably not the case. Most normal people have had this feeling at times, although *déjà vu* can occur in temporal lobe epilepsy.

Overvalued ideas are beliefs that we continue to hold despite lack of proof as to their worth. Like delusions, they cannot usually be challenged by argument or logic; unlike delusions, they are not obviously false. Examples include the superiority of one's own gender, race, political party, or religion. Overvalued ideas are sometimes pursued to the point where they interfere with an individual's functioning, causing suffering to that person or to those around. A common example is racial hatred.

*If they are normal, they're not really symptoms.

The dividing line can be hard to draw: Overvalued religious ideas can shade into religious preoccupation, and from there into delusion. Note the patient's exact words as a baseline for later review.

Depersonalization is an alteration in one's own perception of self. People usually experience it as an uncomfortable feeling of being detached from body or mind; they may have a strange sensation of viewing themselves or of being in a dream. Though insight remains intact, they may worry about going crazy or losing control. In its close relative, *derealization*, people feel that it's the environment that is unreal. Screen for these (often coincident) experiences by asking:

"Have you ever felt unreal? As if you were a robot?"

"Have you ever felt that things around you are unreal?"

Derealization and depersonalization are reasonably common and often normal; they sometimes develop during a period of profound distress or with sleep deprivation. Episodes may last only seconds, but when protracted or repeated and severe enough to cause distress, the individual may be diagnosed as having depersonalization/derealization disorder. These experiences can also occur during bouts of PTSD and with brain pathology. Depression or anxiety often accompanies these symptoms.

CONSCIOUSNESS AND COGNITION

In the next section of the MSE, you evaluate your patient's ability to absorb, process, and communicate information. The clinical tests we commonly use are only approximate, but they can serve as a useful guide.

To introduce these tasks, you might want again to offer reassurance that you often ask these routine questions of new patients. I hope you'll avoid one common mistake of beginning clinicians who, perhaps embarrassed at having to ask such questions, so frequently describe them as "silly." (The logical patient thinks, "If they're silly, why ask them?") Devaluing these tasks can diminish motivation to answer thoughtfully. To someone who wants to know why you're asking, the correct answer is "To help evaluate you." Neither should you refer to them as "simple," which will only increase the discomfort of patients who have difficulty answering. Remember that any test of mental functioning can be traumatic, especially when there is fear of failure. Doing poorly is always stressful, and the patient who stumbles may need some support:

"People can't perform at their best when they feel under pressure."

"Most patients have some difficulty with that task."

In any case, try to emphasize what the patient is able to do:

"You did well on those serial sevens."

"You're doing better than many others have on this test."

(Of course, you should never make this sort of supportive comment unless it is true.)

Attention and Concentration

At this point in the interview, you will already have a good idea of your patient's *attention* (which we'll define as the ability to focus on a current task or topic) and *concentration* (the ability over a period of time to sustain that focus while rejecting other, competing demands). You can get at these qualities in a more formal way from calculations, which assess the ability to focus on a stimulus. Ask your patient to subtract 7 from 100. Once that is done, request another subtraction of 7 from the result, and so on toward 0. Most adults will finish in less than a minute with fewer than four errors. Remember to consider the patient's age, education level, culture, and degree of depression and anxiety when you assess the performance.

Personally, whenever possible, I prefer to evaluate attention during the body of my interview. This possibility can arise, for example, when a patient mentions a date that is years in the past. "Let's see," I'll say, "how old were you then?" I probably won't pursue this sort of testing any further if the patient can come up with the correct age and seems to focus well during our (perhaps prolonged) conversation.

If subtractions prove too difficult—they do assume some education and facility with math—ask your patient to count backward by ones from, say, 87 and to stop at 63. This test of attention is less culture-bound than serial subtractions. We so often ask patients to spell *world* backward that some patients can rattle it off without thinking. Try a different word, such as *strap* or *watch*, but first make sure your patient can spell the word forward. Recalling a series of five to seven digits forward, then backward, accomplishes the same task and is less educationally dependent. *Reduced attention is found in patients with conditions such as epilepsy and cognitive disorders, as well as in patients with schizophrenia and bipolar disorders. Because so much of mental processing hinges on the ability to focus, you should interpret cautiously the rest of your MSE findings when attention is impaired.*

Orientation

To check that your patient is oriented to place, ask:

"Where are we now [city, state, name of the facility]?"

If this draws a blank, ask what type of a facility you are in. *An answer such as "A library" or "Ground Zero" suggests severe pathology, though you should beware of overinterpreting what you hear from a facetious or otherwise uncooperative patient.*

"What is the date?"

Not infrequently, patients will give the correct date and month, but miss the year. Be sure to ask for all components of orientation to time. *Patients will often miss the date by a day or two. This is usually without significance, especially for hospitalized patients who, divorced from their usual routines, tend to lose track of time.*

Whether patients know their own names (orientation to person) should be evident from the earlier portions of an interview. If you detect confusion about time or place, ask about orientation to person:

"Would you tell me your full name again?"

Language

Language refers to the means whereby we understand and express meaning through words and symbols. The areas of language that are usually assessed include comprehension, fluency, naming, repetition, reading, and writing. Their routine assessment can be quickly done; it is especially important in older patients and in those who are physically ill. It is not uncommon for somatization disorder, cognitive disorders, and other mental conditions to be misdiagnosed when a patient actually has a disorder of language.

- The degree of *comprehension* of language should already be evident from the way your patient has responded to conversation during the interview. As a simple test, request some complex behavior, such as this: "Pick up this pen, put it into your pocket, then return it to the table top."
- *Fluency* of language should also be obvious from the patient's use of normal vocabulary and prosody to produce sentences of normal length. Be alert for hesitation, mumbling, stammering, and unusual emphasis.
- Problems with *naming* may be evident if, instead of their names, your patient uses circumlocutions to describe everyday objects. Examples of such a *naming aphasia*:

  Watch band: "The thing that holds it on your wrist."

  Pen: "A whatsis for writing."

Screen for aphasias by asking your patient to name the parts of a ballpoint pen: point (or tip), clip, barrel.

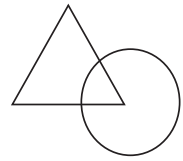
• To test *repetition*, ask your patient to repeat a standard, simple phrase, such as "Tomorrow will be sunny."

• *Reading* is quickly tested by asking the patient to read a sentence or two. Note that even in advanced societies, a small percentage of adults are functionally illiterate. You will need to evaluate the results of this and other tests against what you already know about your patient's educational background. Be prepared to offer support for the embarrassment of the occasional patient who has trouble with this task.

• Test *writing* by asking your patient to write a sentence (you can dictate something if the patient has trouble thinking of one).

• Asking for the names of a pencil and watch tests the patient for *expressive dysphasia*. So does the request to write out a sentence of the patient's choice.

• Test for *apraxia* (the inability to perform a voluntary act, despite intact motor pathways) by asking your patient to copy a simple geometric figure, such as this one:



Inability to reproduce the basic elements of this figure (ignore shakiness and rotation) could indicate an *ideomotor apraxia*. Apraxias can stem from a lesion on the right side of the brain.

If you encounter problems with any of these screening tests, your patient's mental condition may be complicated by a significant neurological dysfunction. You should ask for a neurological evaluation.

Memory

Memory is usually divided into three or four parts. For convenience, let's discuss three: immediate, short-term, and long-term. If you feel uncomfortable with asking any of these questions, you can lead into them:

"Have you had any problems with your memory? I'd like to test it."

Immediate memory (the ability to register and reproduce information after 5 or 10 seconds) is actually more of a test of attention, which you may have already accomplished with serial sevens, counting backward, or just

the way the patient focuses on the interview. But you can assess it again on your way to testing short-term memory. Name several unrelated items, such as a name, a color, and a street address. Then ask the patient for a repetition of these items. This repetition not only assesses immediate memory, but also provides assurance that the patient has understood you.

Should you warn patients that you plan to ask for a repetition later? There are two schools of thought. One advises you to give a heads-up, though I don't think I've ever read the reason why. The other cautions you that such a warning invites cognitive rehearsal, which could mean that some patients benefit from practicing while perhaps paying insufficient attention to the questions you ask in the meantime. Although I've always matriculated in the latter school, perhaps the issue isn't cosmic, only cosmetic; that is, either method may be OK, as long as you are consistent. What you want is to gain a feeling for normal responses to the way you ask your questions.

Five minutes later, test *short-term (recent) memory* by asking your patient to recall the three items. At 5 minutes, most people should be able to repeat the name, the color, and at least part of the address. When you are interpreting the results of this test, be sure to consider your patient's apparent degree of motivation. *Failure on all three parts suggests inattention due to a serious cognitive disorder or to severe stress from depression, psychosis, or anxiety.*

You can best assess *long-term (remote) memory* from the ability to organize the information necessary to relate the history of the present illness. You will also have a good idea from your patient's facility with sequence of events, births of children, and so forth—material that you will have elicited in the course of obtaining the historical information already described. Experts differ as to where the dividing line lies between short-term and long-term memory. Most agree that some sort of consolidation takes place between 12 and 18 months, so that memories stored long-term are not easily forgotten. *Although patients with severe dementias such as Alzheimer's typically retain long-term memories better than short-term memories, even long-retained information will eventually be lost once the disease has progressed far enough.*

Amnesia, that temporary loss of memory often due to physical or psychological trauma, is very different from dementia. It can be encountered in head trauma of all severities, alcohol-related blackouts, PTSD, and dissociative disorders. Amnesia can be hard to ascertain, since the natural answer to "Have you ever suffered from amnesia?" is the unhelpful "I don't remember." You might try:

"Have there been periods of time that you cannot remember at all?"

"Have others ever commented that you have trouble with your memory?"

If you encounter amnesia, try to determine whether it is *fragmentary* (the patient can remember isolated bits from the affected periods of time) or *en bloc* (there is complete loss of memory for that time). You might try to bracket the memory hole with the memories on either side of it ("What's the last thing you can recall just before the period of amnesia begins? What's the first thing you can recall afterward?"). You could also inquire: "Have you asked friends or relatives to try to help you reconstruct what happened then?"

Don't assume that a memory hole means that something bad happened. Clinicians have come to grief through persuading patients that amnesia implies assault or molestation—the so-called "false memory" syndrome.

Occasionally you will encounter a patient who not only is disoriented, but also tries to hide defects of memory by making up responses that sound logical. This unconscious memory creation is called *confabulation*, and it does not signify lying; patients seem truly to believe these stories they tell, which are mostly about themselves. If asked whether you have met previously, such a patient might agree, even though it is the first time you have ever laid eyes on one another. *Confabulation is characteristic of patients whose ability to remember is severely impaired by such disorders as chronic alcoholism with thiamine deficiency.*

A student once asked me the difference between a delusion and a confabulation. Good question, that! A delusional person may misinterpret an actual memory, whereas when someone confabulates, it is to compensate for a memory that should be there, but isn't.

Cultural Information

Some texts no longer even mention cultural information tasks, which mainly assess the patient's remote memory and general intelligence. However, these are a traditional part of the MSE, so you should have some familiarity with the classical questions.

> "Name the five most recent presidents [or prime ministers or other heads of state], beginning with the current one."

Most patients can name four or five presidents (or the like), working backward. Ask them one at a time. Understandably, many patients find it daunting to be asked to "name the last five presidents in reverse chronological order." If a patient misses one, it's fair to try to jog memory: "Let's see, did you leave out anyone?" or "He's hiding between two Bushes."

> "Who is the governor of this state?"
>
> "Name five large cities."
>
> "Name five rivers."

Cautions about interpretation are the same as for counting and serial subtractions, mentioned previously. Alternatively, you might get quite an accurate picture of your patient's interest, intelligence, and memory by asking about current events: outcomes of major sports events, the names of persons running in the next election, and other items of popular cultural significance.

Abstract Thinking

The ability to abstract a principle from a specific example is another traditional test that depends heavily on culture, intelligence, and education. This ability has nothing to do with sanity, contrary to what we were taught half a century ago. Commonly asked abstractions include the interpretation of proverbs, likenesses, and differences. Here are some typical proverbs to interpret:

> "What does it mean when someone says that people who live in glass houses shouldn't throw stones?"
>
> "Can you tell me what this means: A rolling stone gathers no moss?"

Note that some proverbs have more than one interpretation (for instance, gathering moss could be judged as either desirable or not). I accept any logical interpretation.

Similarities and differences are somewhat less culture-bound than proverbs, so you are probably better off asking some of these:

> "How are an apple and an orange alike?" (They are both fruit; both are spherical; both have seeds.)
>
> "What is the difference between a child and a dwarf?" (A child will grow.)

Tests of Cognitive Ability

The Mini-Mental State Exam (or MMSE—not to be confused with the MSE) is sometimes called the *Folstein test* to honor two of its developers. Requiring just a few minutes to administer and score, it extends and quantifies tests of cognition. A result below 24 (of a possible 30) suggests dementia, though a highly educated, intelligent patient may score higher and require formal neuropsychological testing to reveal mild neurocognitive disorder. A good use for the MMSE is to follow the cognitive changes in a patient with dementia.

For years the MMSE was freely available and so became a staple of routine mental health evaluations. Alas, it can no longer be reproduced in its entirety, as it is sold through Psychological Assessment Resources (see

www.minimental.com). Or you can find the criteria in the original article; I've included the reference in Appendix F.

Another test of cognitive ability, the Montreal Cognitive Assessment (MoCA), is more sensitive to mild impairment than the MMSE. Furthermore, it is available for free online (see *www.mocatest.org*). It also has a maximum possible score of 30; a score under 26 suggests cognitive impairment.

Either of these exams yields only an approximation of a person's cognitive abilities. For greater precision yet, you can request formal neuropsychological testing by a qualified psychologist.

Special Note Concerning Intelligence

Precise estimates (there's an oxymoron!) of intelligence are beyond the scope of any initial interview—indeed, of any interaction other than formal testing. Most texts ignore this topic, which would seem important at least to consider because it can so strongly affect aspects of your assessment, especially cognitive state and personality.

In 1983, the psychologist Howard Gardner proposed that there are many types of intelligence. Besides *linguistic* and *logical-mathematical* intelligence (the two spheres that constitute the majority of what gets measured in standard tests), he would include *spatial, bodily-kinesthetic, musical, interpersonal, intrapersonal, naturalistic,* and *existential* intelligence. Although some writers have suggested that this formulation conflates *intelligence* with *ability*, multiple aspects of intelligence encourage the comforting notion that everyone's good at something.

Nonetheless, considered opinion still embraces some sort of general intelligence factor. More than just a number on the page, it can inform your assessment of a person's ability to cope with changes in the environment in the pursuance of life goals. Of course, intelligence can only be measured accurately by means of standardized testing, but as a part of your initial evaluation, you'd like to have at least a rough estimate.

You can probably tell enough about your patient's intelligence (superior, average, low) from historical information—education, occupation—plus your impressions from the interview itself, taking into consideration age, cultural background, and degrees of alertness, cooperation, depression, and psychosis. However, if you'd like yet one more data point on which to hang your hat, you can make a quick estimate of overall IQ with a test published nearly half a century ago by Ian Wilson (the reference is in Appendix F). Ask the patient to multiply 2×3, then 2×6, 2×12, and so on. A correct answer at 2×48 yields an 85% probability that the patient will score in the normal range or better on that standard test of intelligence, the Wechsler Adult Intelligence Scale or WAIS (now in its fourth edition, the WAIS-IV).

INSIGHT AND JUDGMENT

In the context of the mental health evaluation, *insight* refers to the validity of your patient's ideas about whatever problem you're evaluating. The insightful patient recognizes that (1) something is amiss; (2) it can have implications for future well-being; (3) the cause could be biological, psychological, or social (as opposed to the influence of demons or aliens); and (4) some form of treatment is needed. The capacity to participate in psychotherapy or to understand psychodynamics doesn't usually figure into this assessment.

Insight that's deficient has important implications. It can suggest the need for hospitalization or for appointment of a guardian or fiduciary, or for depot medication or another treatment the patient prefers to reject. On the other hand, good insight can increase your confidence that a patient will cooperate with treatment planning, faithfully take medication, and show up for appointments.

To ascertain insight, you can ask:

"Do you think there is something wrong with you?"

"Could the voices you hear be due to illness?"

"What do you think has caused it?"

"What sorts of problems do people have who come here?"

"Do you think you are impaired in any way?"

"Do you think treatment might be in order?"

Insight may be full, partial, or nil. For example, a patient with partial insight may realize that something is wrong but blame others for it. Insight also tends to be fluid—to deteriorate with worsening illness and to improve during remission. *Poor insight is typical of neurocognitive disorders, severe depression, and any of the psychoses (especially schizophrenia and bipolar I disorder with psychotic features).*

You should also try to get a feeling for your patient's self-image by asking:

"What strengths do you think you have?"

"What do you like about yourself?"

"How do you think other people see you?"

Patients' assessment of their own strengths–what they think they are good at–can be important for recommending treatment and estimating prognosis.

Aside from its role in the acceptance of recommended treatment, we may think of *judgment* as the ability to decide upon an appropriate course of action in the pursuit of realistic goals. Some clinicians still assess judgment by asking hypothetical questions such as "What would you do if you found a letter with a stamp on it?" or "How would you react if a fire broke out in a theater when you were attending a performance?" Such abstract questions probably have little bearing on one's ability to get along in the world; you are better off avoiding them. Instead, ask practical questions to assess your patient's judgment:

"What do you expect from treatment?"

"What are your plans for the future?"

In the final analysis, your best appraisal of judgment will probably come from material you have just obtained in an hour or more of interviewing.

When you are reporting the patient's insight and judgment, be sure to give particulars: state the aspects of insight that appear deficient, and give examples of why you think so. Too often, we are content to assign a value judgment ("The patient's insight was limited") and let it go at that—a practice that lacks rigor and, well, good judgment.

WHEN CAN YOU OMIT THE FORMAL MENTAL STATUS EXAM?

The obvious answer to the question posed in this heading remains "Never." The reason is that unless all your information comes from printed records, you make a great number of mental status observations every time you have a conversation. The question we are really posing is this: When can you safely avoid asking the questions contained in the cognitive portion of the MSE (that is, the questions covered in much of this chapter)?

It is seldom risk-free to leave out any test; whenever you do so, it must be with the idea of balancing benefits (saving your time and the patient's possible embarrassment) versus disadvantages (obtaining less in the way of diagnostic information). The disadvantages of testing are usually inconsequential: Most tests are quick, and most patients will accept with reasonably good grace whatever questions you pose. Nonetheless, here are a few situations in which you could abbreviate your MSE by omitting some formal tests of orientation, knowledge, attention, and memory:

Your patient has given a detailed, well-organized history. For example, an outpatient who consults you for a relatively nonthreatening problem (life stress or marital difficulties, perhaps) clearly relates a story that is coherent and devoid of gaps or inconsistencies.

Test results are available. You have a report of recent psychological testing, which will be far more precise than your approximate tests.

The patient is already distressed. If the patient has been quizzed recently by other examiners and is embarrassed or angered by repeated requests, you may want to abbreviate your exam. This may be especially true of patients who have trouble with certain of the tests.

You should not omit any portion of the formal MSE under the following circumstances:

Any forensic exam. Such reports may be scrutinized in a court of law; leave no stone unturned.

Other legal requirements. Commitment proceedings, competency evaluations, and examinations mandated for certain procedures (such as electroconvulsive therapy) almost always require a complete report.

A benchmark record. For example, if you know you'll need to evaluate the results of treatment later, you'd better have an exact record of what the patient was like "before."

Any hint of suicidal ideation or threats of violence. Personal consequences for the patient and potential legal fallout in general mandate the complete exam.

Major diagnoses. Any major condition (especially psychotic, mood, anxiety, neurocognitive, and substance use disorders) must be thoroughly investigated.

Inpatient status. Any patient sick enough to be hospitalized deserves a complete workup.

Possible brain injury. Always do a complete MSE when there is a history of head injury or neurological illness.

A beginning examiner. Performing the complete evaluation over and over will give you both familiarity and facility with it.

CHAPTER 13

Signs and Symptoms in Areas of Clinical Interest

The *areas of clinical interest* are simply a way of thinking about historical and mental status information. The eight groups I'll discuss here include most of the signs and symptoms a mental health professional can expect to encounter. The areas of clinical interest should help you focus your inquiry on the information you will need to devise a differential diagnosis.

Your job is to obtain the facts necessary to assess the importance of any of these areas you encounter to the overall evaluation. Remember that each of them comprises a number of clinical diagnoses that have symptoms in common. In order to decide which diagnosis fits best, you must inquire about symptoms of each of the disorders you have in mind.

As an example of how this process works, consider a patient who has complained of feeling depressed, blue, or "bummed out." You would expect to find some of these additional symptoms of a mood disorder: crying spells, hopelessness, change in appetite and sleep patterns, feeling worse at certain times of the day, low energy, poor concentration, pessimistic outlook, and suicidal ideas or behaviors. Most patients won't have all of these symptoms, but even a couple of them would suggest that your patient could suffer from some kind of a depressive condition. In that case, you should learn whether the symptoms and course of the illness will support one of the mood disorder diagnoses. In other words, first get the data. Later, when all the facts are in, you can decide which of the diagnoses best fits the facts.

In discussing each area of clinical interest, I will present these features:

1. Tip-offs, or the "red flag" symptoms that should alert you to explore further.
2. The main diagnoses. This section covers the most important disorders covered by that area of clinical interest, plus the principal differential diagnoses. I've marked with an asterisk (*) those that I've included in the Appendix B description of diagnoses.
3. Historical information. Here, I briefly explain the importance of each bit of historical data you should ask about.
4. Typical features from the MSE. The current mental status is usually not as helpful as history in sorting out the differential diagnosis, so I have just listed the typical symptoms.

At times it is hard to know where history ends and the mental status begins. For that reason, you might find that some features mentioned under one section seem to belong in another. For example, a patient might report some moods that are not observed during the interview.

In Appendix D, you'll find a semistructured interview that covers the major mental health diagnoses. It gives readers who want it a way to ensure that they've touched all the bases in their interview. I do want to warn you, however, to be careful about interviewing *for* a particular diagnosis. The purpose of the initial interview is to determine what's wrong, not merely to find evidence that will reaffirm your preconceptions—or what another clinician has already claimed. In other words, don't bait a hook to catch a particular kind of fish; rather, you should cast a net to see what you bring up.

PSYCHOSIS

Psychosis means simply that the patient is out of touch with reality, as judged by the presence of hallucinations, delusions, or markedly loosened thought associations. This condition may be either transient or chronic, although with today's treatment methods it is unusual for a person to remain psychotic for extended periods.

Tip-Offs

Symptoms that would make you consider psychosis as an area of clinical interest include the following:

Affect that is flat or inappropriate

Bizarre behavior

Confusion

Delusions

Fantasies or illogical ideas

Hallucinations (of any of the senses)

Insight or judgment that is disturbed

Muteness

Perceptual distortions or misinterpretations

Social withdrawal

Speech that is incoherent or hard to follow

Main Diagnoses

A patient who presents with psychosis is likely to have one of three principal diagnoses: an organic psychosis (that is, one due to a medical illness or to substance use), schizophrenia, or some sort of mood episode—a major depressive episode with psychosis (which could signal either major depressive disorder or bipolar I disorder) or severe mania (bipolar I). Of those, you'll encounter mood episodes and schizophrenia most frequently. However, here is a more complete list:

Schizophrenia*

Major depressive episode*

Manic episode*

Neurocognitive disorders, such as delirium* due to a variety of causes

Substance/medication-induced psychotic disorder* (e.g., due to alcohol)

Brief psychotic disorder

Schizophreniform disorder*

Schizoaffective disorder*

Delusional disorder*

Historical Information

Age at onset. Schizophrenia tends to begin early (late teens or 20s); delusional disorder starts in middle to late life.

Alcohol or drugs. Many psychotic patients use substances. Check the chronology. If the psychosis began first, schizophrenia with secondary substance misuse is more likely. If substance use began first, the psychosis could be a secondary diagnosis; schizophrenia is less likely.

Depression. If there is a past or present severe depression, consider the diagnosis of a mood disorder with psychosis.

Environmental stress. Severe stress that precedes the onset of psychosis suggests a diagnosis of brief psychotic disorder.

Family history. Schizophrenia and mood disorders tend to run in families; having a relative with either condition increases the likelihood of that diagnosis for the patient.

Length of illness. The longer a psychosis has lasted, the more likely schizophrenia is to be the final diagnosis.

Loss of drive, volition, interest. These symptoms are typical of the later phases of schizophrenia.

Onset. Sudden onset (a few days to a few weeks) suggests a cognitive or mood disorder with psychosis. The longer and more gradual the onset—up to several years in some cases—the more likely this psychosis is to be schizophrenia.

Physical illness. Cognitive psychoses are associated with a number of health risk factors: endocrine or metabolic disorders, tumors, toxic substance exposure, trauma, and a variety of neurological and medical diseases.

Previous episode with recovery. Mood disorders tend to be episodic illnesses; these patients are more likely to recover completely than are those with schizophrenia.

Schizoid or schizotypal premorbid personality. Long-standing character traits such as aloofness, emotional withdrawal, few friends, or odd beliefs or behaviors sometimes precede the onset of schizophrenia.

Unemployment or reduced job level. If unemployment or underemployment has been present for years, and especially if the reduced job level continues after recovery from an acute episode, schizophrenia is more likely than if the patient worked at a high-grade, demanding job until just recently.

Note on first-rank symptoms. A much-discussed set of hallucinations and delusions is that of Kurt Schneider's *first-rank symptoms*, any one of which he believed was diagnostic of schizophrenia. Although subsequent research has shown that patients with other disorders may also report these symptoms, you will encounter the concept of first-rank symptoms often enough to warrant a brief listing:

Audible thoughts

Delusional perception, in which a normal observation has abnormal significance for a patient; for example, when a patient was served a grilled cheese sandwich for lunch, he "knew" that his aunt was about to die

Delusions of influence

Delusions of thought control

More than one voice talking about the patient

Voices commenting on the patient's actions

Somatic hallucinations (body sensations produced by outside influence)

Thought broadcasting

Mental Status Examination

- Appearance and behavior
  - Abnormalities of motion
    - Reduced activity
    - Pacing
    - Posturing
    - Rigidity
    - Negativism
    - Grimacing
    - Stereotypies
  - Clothing eccentric or disheveled
  - Hyperalertness
  - Neglect of hygiene
- Mood
  - Flat or silly
  - Perplexity about identity
- Flow of thought
  - Speech restricted in amount
  - Mute
  - Incoherent
  - Loosened associations
  - Illogical ideas
  - Preoccupied with fantasies
- Content of thought
  - Hallucinations: When? Where?
- Hallucinations *(cont.)*
  - Auditory
    - Voices?
    - If so, whose?
    - Audible thoughts?
  - Visual
  - Tactile
  - Taste
  - Smell
- Delusions
  - Death
  - Erotomania
  - Grandeur
  - Guilt
  - Ill health or bodily change
  - Jealousy
  - Passivity
  - Persecution
  - Poverty
  - Reference
- Language usually not impaired
- Cognition generally preserved
- Insight often absent
- Judgment may be impaired in the acute phase

MOOD DISTURBANCE: DEPRESSION

Depression means a mood that is variously described as "blue," "low," or "melancholy"—as well as "depressed." This low mood must be persistent, usually lasting at least a week or two. It is often described as a marked change from the patient's normal mood. Some people will tell you that they don't feel depressed; they just don't experience pleasure (this state is

called *anhedonia*). The information needed for the history of the present illness addresses both cause of depression (see later) and severity.

Tip-Offs

You should investigate depression if your patient presents with any of these symptoms:

Activity level that is either markedly decreased or increased (agitated)

Anxiety symptoms

Appetite changes

Concentration poor

Death wishes

Depressed mood

Interest decreased for usual activities (including sex)

Sleeplessness or excessive sleepiness

Suicidal ideas

Tearfulness

Use of drugs or alcohol

Weight loss or gain

Worthlessness

Main Diagnoses

Many of the same physical diseases that produce psychosis can also lead to depression. However, the principal problem with diagnosis is differentiating *primary* depression (or depression that is chronologically the first disorder to appear) from *secondary* depression (or depression that begins after and is caused by another mental or personality disorder). Principal diagnoses to consider are these:

Major depressive episode* (as part of either major depressive disorder or bipolar I or bipolar II disorder)

Melancholia*

Dysthymia (now called persistent depressive disorder in DSM-5)*

Premenstrual dysphoric disorder

Seasonal pattern in mood disorder

Secondary depression

Historical Information

Alcohol and drugs. Substance use is a principal finding preceding the onset of secondary depression.

Anhedonia. The patient cannot feel pleasure. In some patients, this feeling may occur as an alternative to the mood of depression.

Atypical features. Stress-related depression may have symptoms of excessive sleep (hypersomnia), increased appetite, and weight gain; patients may feel better in the mornings and when they are with people they like. These features are called *atypical* because depressed patients more usually have insomnia, feel better in the evenings, complain of decreased appetite and weight, and *don't* feel better with pleasant society.

Change from usual self. Patients who have severe bipolar depressed episodes or unipolar depression often report that the way they feel is a "complete change from the way I used to feel."

Environmental stress. Any severe environmental stressor can be associated with depressed mood. A depression that remits as soon as the stressor lifts is sometimes called *reactive*. Non-stress-related depressions are sometimes referred to as *endogenous* (springing from within); people sometimes describe them as "coming out of nowhere." Reactive depressions are usually less severe than those of the endogenous type, and are less likely to require treatment.

Episodic illness. Has there been a previous episode of depression? Did the patient recover completely? "Yes" answers suggest bipolar depressed episodes, unipolar depression, or a mood disorder with seasonal pattern (see below). A chronic, low-intensity depression that has been present for years is typical of persistent depressive disorder (dysthymia).

Family history of mood disorder. This is a classical finding in severe mood disorder, which is often at least partly inherited.

Indecisiveness. Inability to make up one's mind, even regarding minor details, is emblematic of severe depression.

Isolation. Withdrawal from friends or family suggests a severe depression such as melancholia.

Mania ever. The distinction between a bipolar depressed episode and major depressive disorder is easily made with the finding of previous episodes of mania.

Neglect of hobbies, activities. Loss of interest in usual activities accompanies severe depression.

Premenstrual pattern. Women whose depressive symptoms occur mainly before their periods begin may have premenstrual dysphoric disorder.

Recent loss (bereavement). This is another common environmental stressor that can precede depression.

Seasonal pattern. Some patients report regular onset of depression at a particular season of the year (typically fall or winter), with full remission later (typically springtime). Such patients may be diagnosed as having a mood disorder with seasonal pattern.

Sex interest decreased. Loss of libido is a classical symptom of moderate to severe depression.

Suicide ideas, attempts. For any depression, ask about psychological and physical seriousness of previous attempts. Are there current ideas about suicide? Does the patient have a plan, and the means, to act upon these ideas?

Trouble thinking or concentrating. These symptoms are usually found in moderate to severe depression.

Vegetative symptoms. Classical for severe depression with melancholia are terminal insomnia (the patient awakens early and cannot return to sleep), decreased appetite, weight loss, and low energy or fatigue. Patients tend to feel better in evenings than mornings, and don't improve much when with people whose company they normally enjoy.

Mental Status Examination

- Appearance and behavior
  - Tearful
  - Decreased attention to appearance
  - Decreased interest in usual activities
  - Slowed actions
  - Agitation
- Mood
  - Sad face
  - Anxiety
- Flow of thought
  - Slowing
- Content of thought
  - Guilt feelings
  - Ruminations
  - Hopelessness
  - Worthlessness
  - Loss of pleasure
- Content of thought *(cont.)*
  - "Better off dead"
  - Death wishes
  - Suicide ideas, plans
  - Mood-congruent delusions
    - Guilt
    - Sin
    - Worthlessness
    - Ill health
    - Poverty
- Language not usually affected
- Cognition
  - Usually intact
  - May have "pseudodementia"
- Insight and judgment
  - May deny feeling depressed
  - May deny possibility of improvement

MOOD DISTURBANCE: MANIA

Manic patients describe their moods as "high," "hyper," "exalted," "excited," or "euphoric"; sometimes they are mainly irritable. Although the condition of mania has been recognized for more than 100 years, these patients are often misdiagnosed as having schizophrenia. Cognitive disorders can sometimes present with symptoms of mania.

Tip-Offs

Consider mania when you are confronted with any of the following symptoms:

Activity level increased
Distractibility
Grandiose sense of self-worth
Judgment deteriorating
Mood euphoric or irritable
Planning many activities
Sleep decreased (reduced need for sleep)
Speech rapid, loud, hard to interrupt
Substance use recently begun or increased
Thoughts moving rapidly from one idea to another

Main Diagnoses

Most manic patients also have episodes of (often severe) depression. Cyclothymia, a milder condition in which high moods that are not psychotic alternate with depressed ones, is the other principal possibility to consider. Differential diagnoses includes the following:

Mania* (bipolar I disorder, manic episode)
Bipolar II disorder
Cyclothymia
Organic mood disorder

Historical Information

Alcohol misuse. Sometimes this can be an attempt to lessen the uncomfortable feelings of being speeded up.

Concentration decreased. Manic patients often start projects that they do not complete.

Episodic illness. A previous episode of mania or depression with complete recovery usually clinches the diagnosis. If so, look especially for rapid cycling (four or more switches between highs and lows in the course of a year). These episodes, which may be as brief as a few days, have implications for the type of treatment that may be effective.

Insomnia. This is often experienced as decreased need for sleep.

Judgment poor. This appears as a history of spending sprees, legal troubles, or sexual indiscretions.

Libido increased. Manic exuberance can lead to promiscuity, pregnancy, and the risk of sexually transmitted disease.

Personality change. At the extreme, a normally quiet, unassuming person abruptly becomes boisterous, argumentative, or ill-tempered.

Physical conditions. Disinhibition similar to mania can be encountered after head trauma and in various conditions such as brain tumors and endocrine disorders.

Relationships disrupted. Friends and family have difficulty coping with markedly changed behavior.

Sociability increased. Manic patients may excessively enjoy parties and other social gatherings.

Work-related problems. Loss of concentration and preoccupation with grandiose plans contribute to decreased performance on the job or in school.

Mental Status Examination

- Appearance and behavior
  - Excited, agitated
  - Hyperactive
  - Increased energy
  - Loud speech
  - Flamboyant or bizarre dress
  - May be threatening or assaultive
- Mood
  - Euphoric
  - Irritable
  - Rapidly changing moods
- Flow of thought
  - Racing thoughts
  - Flight of ideas
  - Pressured speech
- Flow of thought *(cont.)*
  - Wordplay, jokes
  - Distractible
- Content of thought
  - Self-confident
  - Increased religiosity
  - Full of schemes and plans
  - Grandiosity that may be delusional
- Language usually not affected
- Cognition usually intact
- Insight and judgment
  - Lack of insight into the fact of being ill
  - Poor judgment (refuses hospitalization, treatment)

SUBSTANCE USE DISORDERS

Substance misuse is defined by the culture in which it occurs. In most segments of our culture (some religions, such as the Mormons, for example, are significant exceptions), the majority of adults use substances—if only caffeine. Whether we consider a person to be misusing a substance depends not simply on the amount or frequency of use, but also on the consequences of this behavior. These consequences may be behavioral, cognitive, legal, financial, and physical. Many of them also affect society as a whole.

Tip-Offs

The following symptoms should lead you to consider a diagnosis of a substance use disorder:

Alcohol use greater than one or two drinks per day

Arrests or other legal problems

Financial problems: the patient spends money needed for other purposes

Health problems: blackouts, cirrhosis, abdominal pain, vomiting

Illegal substance use

Job loss, tardiness, demotions

Memory impairment (blackouts from drinking or drug use)

Social problems: fights, loss of friends

Main Diagnoses

In DSM-5, these disorders are called [substance] use disorders and [substance/medication]-induced [mood, psychotic, etc.] disorders. Substance-induced neurocognitive disorders, the brain syndromes that many people who heavily use substances also have at one time or another, will be considered in the "Difficulty Thinking (Cognitive Problems)" section.

The classes of substances that are recognized as subject to misuse are given below. Many substance users will use more than one of these classes.

Alcohol

Amphetamines

Cannabis

Cocaine

Hallucinogens (including phencyclidine [PCP])
Inhalants
Nicotine
Opioids
Sedatives, hypnotics, anxiolytics

Substance use can occur as a solitary diagnosis, but it is often associated with another major mental health diagnosis or personality disorder. Those you should especially look for include the following:

Mood disorders (depression and mania)
Schizophrenia
Somatization disorder (somatic symptom disorder in DSM-5)
Antisocial personality disorder

Historical Information

Abuse. Formerly used to denote those who had problems resulting from use but were not actually dependent, this term should now be understood simply to mean use of any substance, including prescription medications, that's greater than is good for the individual.

Activities used to obtain supply. These include drug sales, theft, robbery, and prostitution.

Age at onset. How old was the patient when substance use began? For alcohol use, women may have a much later age of onset than men.

Chronology. If there is an associated mental disorder, which came first? For example, if alcoholism chronologically precedes depression, the depression is regarded as secondary.

Dependence. Dependence means, in essence, that behavior changes because of the person's use of the substance. The following symptoms are the sorts of behavioral alterations that DSM-5 uses to define a substance use disorder. (The first two don't usually apply to cannabis or the hallucinogens.)

1. Tolerance (the patient needs more of the substance to produce the same effect or obtains less effect with the same dose).
2. Withdrawal (the patient experiences withdrawal symptoms typical for the substance or takes more of it to avoid withdrawal).
3. More of the substance is used than the patient intends.
4. The patient tries without success to control substance use.

5. The patient spends much time obtaining or using the substance or recovering from its effects.
6. Substance use causes the patient to give up important work/educational, social, or recreational activities.
7. Despite awareness that it has caused physical or psychological problems, the patient continues to use the substance.
8. The patient repeatedly uses substances even when it is physically dangerous to do so (such as driving while intoxicated).
9. Because of repeated use, the patient fails to carry out major obligations at home or work/school (repeated absences, neglect of children or house, poor work performance).
10. The patient keeps using the substance despite knowing that it has caused or worsened social or interpersonal problems (fights, arguments).
11. Finally, the patient craves the substance. Of course, this intense desire is not itself a behavior, but rather the driving force behind the above-listed behavioral symptoms.

Emotional/behavioral disorders. Especially frequent complications include psychosis, mood syndromes, anxiety syndromes, delusional disorder, and delirium on withdrawal.

Frequency of use. How often has each substance been used? Has the pattern changed with the current episode?

Health problems. Has deteriorating health been suggested by evidence such as cirrhosis, stomach disorders, wasting, tuberculosis, or respiratory problems?

Legal problems. Has the patient been arrested or jailed for possession, sales, or for criminal activities to finance supply? A history of criminal activity occasioned by the need to obtain money for drugs must be distinguished from antisocial personality disorder (which may be the correct diagnosis if illegal activities have been undertaken when the patient was clean and sober).

Needle sharing. If intravenous usage is reported, has the patient ever used dirty needles? Had hepatitis? How recently has there been a test for HIV?

Pattern of use. Has there been continuous, episodic, or binge usage? If more than one drug is involved, what is the pattern for each?

Personality change. How has drug use affected the way the patient relates to others? Has there been a general loss of motivation (especially likely with long-term use of cannabis or hallucinogens)?

Relationship problems. These include divorces, separations, and fighting. Some couples stay together only because of a common interest in drug use.

Route of administration. Any of the following means can be used: swallowing, snorting, smoking, subcutaneous, intravenous, rectal, vaginal.

Mental Status Examination

- Appearance
  - Red-faced
  - Tremor
  - Disheveled
- Mood
  - Depressed
  - Anxious
  - Belligerent
- Flow of thought
  - Often talkative
- Content of thought
  - Maudlin
  - Demanding
  - Hallucinations
    - More often visual
    - May be auditory
- Language
  - Fluency reduced (mumbling, slurred speech)
- Cognitive
  - May show cognitive signs if there is a concomitant neurocognitive disorder
- Insight and judgment
  - May reject the diagnosis
  - Patients often refuse treatment or sign out against advice

SOCIAL AND PERSONALITY PROBLEMS

Personality traits are patterns of behavior or thought that persist throughout adult life. To be diagnosable as personality disorders, traits must be pronounced enough to cause the patient functional impairment (work/educational, social, or emotional) or personal distress.

Tip-Offs

You should consider social and personality problems whenever your patient has any of the following characteristics:

- Anxiety
- Behaviors that seem odd or bizarre
- Dramatic presentation
- Drug or alcohol misuse

Interpersonal conflict

Job problems

Legal difficulties

Marital conflicts

Personality disorders must be distinguished from ordinary problems of living that are not mental disorders. The latter can include borderline intellectual functioning, academic problems, marital and other family problems, job problems, and uncomplicated bereavement.

Main Diagnoses

Although many personality disorders have been proposed over the years, only the 10 given below currently enjoy official diagnostic blessing. Adult patients who do not fully meet criteria for one of these diagnoses but have long-standing impairments of self (that is, identity or self-direction) *and* impairments of an interpersonal nature (empathy or intimacy) may be diagnosed as having unspecified personality disorder.

Antisocial*

Avoidant*

Borderline*

Dependent

Histrionic

Narcissistic*

Obsessive–compulsive (personality disorder)*

Paranoid

Schizoid

Schizotypal*

Important differential diagnoses for any personality disorder, including those other than the officially recognized 10 listed above, include these mental disorders:

Bipolar I disorder*

Major depressive disorder*

Dysthymia (persistent depressive disorder)*

Schizophrenia*

Delusional disorder*

Substance use disorders

Obsessive–compulsive disorder*

Personality change due to another medical condition

Historical Information

Many traits have been linked to personality disorders. For purposes of description, I have used several common headings. This list makes no pretense of completeness; it does present traits that clinicians consider important in defining currently recognized personality disorders. This is some of the information you should pursue in the quest of a personality disorder diagnosis.

Callousness. Forces sexual activity on others; takes advantage of others for personal gain; humiliates others publicly; uses harsh discipline; takes pleasure in suffering of others.

Carries grudges.

Childhood delinquency. Truancy; starts fights; fights with weapons; runs away; is cruel to animals or people; destroys property; sets fires.

Compliance is excessive. Volunteers for unpleasant tasks so as to be liked by others; agrees with people to avoid rejection.

Concern for others is lacking. Self-centered; unable to recognize how others feel.

Criticism is rejected. Resents useful suggestions; easily hurt by others.

Dishonesty. History of frequent lying; history of stealing, robbery, or conning others.

Impulsivity. Wanders without a fixed abode; sexual indiscretions; shoplifts; reckless disregard for personal safety.

Indecisiveness. Avoids making decisions or depends on others to make them; vague about goals.

Indifferent to praise.

Inflexibility. Reluctant to do things that differ from routine; perfectionism that interferes with task completion; preoccupation with rules, lists, order; misses the forest for the trees; resists letting others have their way; rigid about morality, ethics.

Insecurity. Feels uncomfortable when alone; won't get involved unless sure of being liked; fearful of self-embarrassment in social situations;

exaggerates risks of doing something outside the routine; afraid of being abandoned; feels helpless or uncomfortable, so avoids being alone.

Irresponsibility. Defaults on financial obligations such as family support or debts; unable to hold a job; fails to do a reasonable share of the work; "forgets" obligations; puts things off.

Mood instability. Mood fluctuates more rapidly or more widely than is usually considered normal for the circumstances. May be quick to show anger; "hair-trigger temper."

Physical aggression. Fighting or assaults.

Saves objects of no value.

Sex drive is low.

Sociability is low. Is a loner (prefers solitary activities); uncomfortable in social situations or with strangers; avoids close relationships.

Stinginess. Shows lack of generosity with money or time.

Suicidal ideas or behavior; nonsuicidal self-harm.

Suspiciousness. Reluctance to confide in others; easily slighted; reads hidden meaning into innocent remarks or situations; expects to be exploited or harmed by others; questions loyalty of friends or fidelity of spouse/partner.

Trusts others excessively. Chronically chooses associates or situations that lead to disappointment.

Unstable interpersonal relationships.

Workaholism.

Mental Status Examination

Appearance and behavior
- Lacks sense of humor
- Hypervigilant
- Argumentative
- Appears tense
- Reluctant to confide
- Sexual seductiveness that is inappropriate
- Overly concerned with appearance, attractiveness

Mood
- Hostile or defensive
- Temper; inappropriate, intense anger
- Exaggeratedly emotional speech, behavior
- Denies experiencing strong emotions
- Feels empty or bored
- Lacks remorse for hurting others

Mood *(cont.)*
- Shallow, shifting emotions
- Apathy
- Restricted or inappropriate affect
- Cool, aloof, or silly

Flow of thought
- Vague speech
- Odd speech (vague, digressive, impoverished)

Content of thought
- Expects to be exploited
- Questions loyalty of friends
- Suspects hidden meanings
- Fantasies of success, power
- Ideas of reference (e.g., "as if" strangers talk about patient)
- Odd beliefs, superstitions or magical thinking, illusions
- Uncertainty about identity (self-image, sexual orientation, long-term goals, values)

Content of thought *(cont.)*
- Frequently requests reassurance or approval; fishes for compliments
- Fears being embarrassed
- Judgmental of self and/or others
- Unreasonably devalues authority figures

Language: no abnormalities are typical

Cognition: no abnormalities are typical

Insight and judgment
- Exaggerates accomplishments
- Lacks remorse for behavior
- Feels others make unreasonable demands
- Overvalues own work; self-important; feels problems are unique; sense of entitlement

DIFFICULTY THINKING (COGNITIVE PROBLEMS)

A wide variety of physical and chemical insults can interfere with thinking. These causes include the following:

Brain tumors

Head trauma

Hypertension

Infections

Metabolic disorders

Postoperative complications

Seizure disorders

Toxic substances or withdrawal from psychoactive substances

Vitamin deficiency

Tip-Offs

Any of the following should stimulate further investigation of cognitive problems:

- Bizarre behavior
- Confusion
- Decreased judgment
- Delusions
- Hallucinations
- Memory defects
- Mood fluctuations
- History of ingesting toxins

Main Diagnoses

Physical or chemical brain dysfunction produces abnormalities of behavior or thinking that can be either temporary or permanent. The types of problems include these:

- Amnestic syndrome
- Anxiety disorders
- Delirium*
- Delusional syndrome
- Dementia (DSM-5 calls it major neurocognitive disorder)*
- Dissociative disorders
- Intoxication and withdrawal
- Psychosis of intoxication or withdrawal
- Mood syndrome
- Personality change due to another medical condition

The important differential diagnoses include the starred diagnoses/syndromes in the previous group, plus these:

- Depression*
- Schizophrenia*
- Substance use disorders*

Note that delirium and dementia may coexist.

Historical Information

Age at onset. Dementia is most commonly encountered in elderly persons; delirium is common in children and in older people. Either can occur across the age spectrum.

Course. May be stable, fluctuating, deteriorating, or improving. If the damage is structural (such as following massive brain trauma), there tends to be some permanent dysfunction, even though improvement may occur. Patients with dementia (such as due to Alzheimer's disease) tend to deteriorate progressively.

Depressive disorder. It is especially important to know about a history of depression and current depressive features, because pseudodementia, one of the possible presentations of severe depression, is a completely treatable mood disorder that isn't a neurocognitive disorder at all.

Difficulty providing self-care. Often this is what drives family members to bring demented patients for care.

Fluctuating symptoms and mental status. Such fluctuations are especially characteristic of delirium.

Head trauma. Trauma can produce a subdural hematoma, which causes symptoms days to weeks later. Bleeding inside the skull can also cause an epidural hematoma, producing symptoms within hours or days. Also be alert for loss of memory that can result from concussion.

Impulsivity. Demented patients lose the ability to judge what is acceptable behavior; consequently, they act on impulses they previously would have suppressed. As a reaction to either fear or confusion, delirious or demented patients may run away. Demented patients may spend money heedlessly, though this behavior occurs without the grandiose quality it has in mania.

Laboratory testing. This should be consistent with the suspected cause of any cognitive syndrome.

Memory loss. Defective memory is characteristic of the dementias. Recent memory is affected most often, though long-term memory can also be involved in severe dementia. Some patients consciously try to compensate for defects in memory by confabulating—making up stories.

Onset. The development of symptoms may be rapid or insidious, depending on the cause and nature of the disorder. Rapid onset is characteristic of disorders caused by strokes, infections, or trauma; defects from vitamin deficiencies and brain tumors may develop gradually.

Personality change. Many symptoms of cognitive syndromes involve a change from the patient's previous personality. These include outbursts of rage or combativeness, social withdrawal, coarsening of behavior (crude

jokes), and neglect of grooming or hygiene. One patient with Alzheimer's dementia who had always welcomed racial diversity shouted racist comments. Excessive neatness (sometimes called *organic orderliness*) can develop.

Psychotic symptoms. Delusions, usually persecutory, can occur in dementia (patients with Alzheimer's often believe that people steal from them). Delusions may be indistinguishable from those of schizophrenia. Hallucinations commonly occur in delirium, but they are usually visual.

Sleep–wake cycle changes. Delirious patients are typically drowsy, although some have trouble falling asleep; vivid dreams or nightmares occur.

Suicide attempts. The presence of suicidal behavior should cause you to consider the diagnosis of major depression, although attempts (and completions) can occur in the dementias.

Mental Status Examination

- Appearance and behavior
  - Disheveled
  - Tremor
  - Restlessness
  - Picking at bedclothes, clothing
- Mood
  - Affect bland or shallow
  - Anger
  - Anxiety
  - Apathy
  - Depression
  - Euphoria
  - Fear
  - Irritability
- Flow of thought
  - Slurred speech
  - Perseveration
  - Rambling, incoherent
  - Loosening of associations
- Content of thought
  - Suspiciousness
  - Current suicidal ideas
  - Illusions
  - Psychotic features
    - Delusions
    - Hallucinations (especially visual)
- Language
  - Comprehension decreases with advancing dementia
  - Fluency is often preserved, even with moderate dementia
  - Naming: aphasias
- Cognition
  - Drowsy, hard to stay awake
  - Disorientation
    - Not knowing the date may be an early symptom of delirium
    - Disorientation to place, person are later symptoms (especially dementia)
  - Impaired abstract thinking (similarities)
  - Low attention span (easily distractible) is found especially in delirium
  - Impaired memory
- Insight and judgment
  - Impaired judgment

ANXIETY, AVOIDANCE BEHAVIOR, AND AROUSAL

Conditions in this area of clinical interest have in common anxiety symptoms that can result in attempts to avoid the stimulus.

Tip-Offs

Symptoms that would cause you to explore this area include any expression of anxiety or fear, as well as somatic symptoms that suggest breathing or heartbeat problems when there is no known basis for concern.

Anxiety
Chest complaints (pain, heaviness, trouble breathing, palpitations)
Compulsive behavior
Fear of objects, situations, dying, impending doom, going crazy
Nervousness
Obsessional ideas
Panic
Trauma (history of severe emotional or physical experience)
Worries

Main Diagnoses

The principal disorders covered by this area of clinical interest include:

Panic disorder*
Generalized anxiety disorder*
Specific phobia*
Agoraphobia*
Obsessive–compulsive disorder*
Posttraumatic stress disorder (PTSD)*

Although anxiety symptoms are found in nearly every mental disorder, the important differential diagnoses include the following:

Depression (various specific diagnoses)*
Substance-induced disorders
Schizophrenia*
Somatization disorder (somatic symptom disorder in DSM-5)*

Historical Information

Age at onset. Most of these conditions begin when the patient is relatively young. Animal phobias begin in childhood; situational phobias usually begin in the 30s.

Agoraphobia. May occur with or without panic disorder. Occurs in situations from which escape is difficult or embarrassing, such as being away from home, in a crowd, in a car, or on a bridge.

Alcohol or drug use. This could be either a cause or an effect of anxiety symptoms.

Anticipatory anxiety. Common in phobias, this sensation of dread is experienced for minutes to hours before the arrival of a feared stimulus (such as speaking in public).

Caffeine intake. Excessive coffee (or tea) drinking can cause anxiety symptoms.

Circumstances of panic attacks. How many attacks have there been, and in what period of time? Were they unexpected? (Attacks in panic disorder tend to arise spontaneously.)

Compulsions. The most common compulsions are handwashing, checking, counting, and routines that must be followed (such as at bedtime). They may occur as rituals (rules) or as "antidotes" or responses to obsessions.

Depressive symptoms. Determine whether these came before the anxiety syndrome, (suggesting primary depression) or after (suggesting that the depression is secondary).

Duration of panic attacks. Individual panic attacks last only a few minutes, but they may recur over a period of weeks, months, or years.

Frequency of panic attacks. They usually occur several times a week.

Lifestyle constriction. As a result of anxiety, does the patient stay at home or avoid specific situations or objects? This may be true for specific phobia, obsessive–compulsive disorder, PTSD, agoraphobia, and panic disorder.

Mental content of panic attacks. Patients may fear that they are going to die, lose control, or lose their minds.

Obsessions. Most common are ideas of (1) harming or killing and (2) swearing (blaspheming). These ideas persist despite the patient's recognition that the ideas are senseless and alien.

Physical symptoms of anxiety. Most of the same physical sensations occur in panic attacks and in anxiety and related disorders:

- Breathlessness
- Chest pain
- Chills or flushes
- Dizziness
- Dry mouth
- Fatigability
- Frequent urination
- Heart palpitations
- Lump in throat
- Muscle tension
- Nausea
- Restlessness
- Sweating
- Tremor

Prescription medication use. Clinicians often prescribe, and patients with anxiety often resort to, drugs in an attempt to keep symptoms in check.

Social anxiety disorder. This typically involves fear of performing, speaking, or eating in public; of using a public toilet; or of trying to write when someone is watching.

Specific phobias. The most common are fears of air travel, animals, blood, closed-in places, heights, and injury.

Stressors. A severely traumatic physical or emotional experience is a required precipitant for PTSD.

Worry. Unwarranted or excessive concern about multiple real-life circumstances is characteristic of generalized anxiety disorder. Examples would include losing the house to the bank just months before the mortgage is paid off, and being fired when one is the favorite of the company president.

Mental Status Examination

- Appearance and behavior
  - Hypervigilance (scanning the environment)
- Mood
  - Depression
  - Anxiety
- Content of thought
  - Obsessional ideas
  - Killing
  - Blasphemy
- Insight and judgment
  - Insight usually retained that the fear or behavior is unreasonable
  - Tries to resist

PHYSICAL COMPLAINTS

Physical illness (anatomically demonstrable heart attacks, asthma, ulcers, allergies, and the like) must always be a prime concern of any clinician whose patient voices somatic complaints. But many patients come to mental health care complaining of physical symptoms for which inadequate basis in physiology, chemistry, or anatomy can be found. Such symptoms have historically been called *hypochondriacal* or *psychosomatic*. Often, by the time such a patient finally seeks help from a mental health clinician, there has already been a full range of medical tests and evaluations. Because certain demographic and symptom features are held in common, I have included anorexia nervosa and bulimia nervosa in this group.

Tip-Offs

Consider this area of clinical interest if your patient presents any of the following problems:

- Appetite disturbance
- Depression that is chronic
- History that is complicated
- Multiple complaints
- Physical symptoms unexplained by known illness (especially neurological symptoms such as pain, convulsions, sensory loss)
- Sexual or physical abuse in childhood
- Substance misuse in a woman
- Treatment failures that are repeated
- Vague history
- Weakness that is chronic
- Weight changes (up or down)

Main Diagnoses

The principal diagnoses in this area include the following:

- Anorexia nervosa*
- Body dysmorphic disorder
- Bulimia nervosa
- Hypochondriasis (illness anxiety disorder in DSM-5)

Pain disorder or chronic pain syndrome (somatic symptom disorder with predominant pain in DSM-5)

Somatization disorder (somatic symptom disorder in DSM-5)*

Other disorders that should be considered in patients who complain of physical symptoms are these:

Depression*

Panic disorder*

Physical illness

Substance-related disorders*

Historical Information

Age at onset. Most of the mental disorders in this group begin early (childhood or adolescence). Hypochondriasis usually begins in the 20s, and pain disorder in the 30s or 40s.

Childhood physical or sexual abuse. You should always ask about abuse, which is common in patients with somatization disorder.

Chronic pain. In pain disorder, there is no known basis for pain, or the pain is out of keeping with a known physical cause.

Doctor shopping. A relentless search for a cure frequently accompanies the DSM-IV somatoform disorders (DSM-5 somatic symptom and related disorders). It may lead to repeated, fruitless medical evaluations.

Environmental stress. Social problems (marital, job, interpersonal) may impel patients to seek mental health treatment for what they perceive as physical problems.

Fear of medical illness that the patient doesn't have. The nondelusional idea that the person is ill persists despite (often repeated) reassurances to the contrary. This is the cardinal symptom of hypochondriasis (DSM-5 illness anxiety disorder).

Operations. Patients with somatoform disorders (somatic symptom and related disorders) often have a history of multiple surgical procedures.

Medical illness in childhood. Did the patient receive attention for being ill as a child? In some cases this factor may underlie the somatization.

Physical defect (imagined or exaggerated). The essential symptom in body dysmorphic disorder, this idea is not usually of delusional intensity.

Patients with anorexia nervosa typically regard themselves as appearing overweight, even when they are obviously emaciated.

Secondary gain. This occurs when a person receives attention or support for being ill; it is classical for somatization disorder and other somatic symptom disorders.

Suicidal ideas, behavior. These patients often threaten or attempt suicide; occasionally, they succeed.

Substance use. Misuse of alcohol or drugs frequently complicates the disorders in this group.

Mental Status Examination

- Appearance and behavior
  - Dramatic presentation
  - Flashy dress
  - Ingratiating manner
  - Exaggerated mannerisms
  - Marked wasting
- Mood
  - Indifference toward symptom (*la belle indifférence*)
  - Anxiety
  - Depression
- Flow of thought: no abnormalities are typical
- Content of thought
  - Centers on physical (sometimes imagined) mental illness
- Language: no abnormalities are typical
- Cognition: no abnormalities are typical
- Insight and judgment
- Overinterprets physical symptoms

CHAPTER 14

Closure

An hour usually provides enough time to explore the reasons for seeking treatment and to obtain a great deal of personal background information about your patient. During this time, you should also have conducted a formal MSE. Even though there is still much you would like to know, you probably shouldn't push the interview too much further. You're conducting an interview, not a test of endurance, and you need to be fresh enough to keep evaluating what you hear and see. Perhaps the arrival of another patient indicates that you will have to finish next week, or the time of day could suggest that you return tomorrow. Or, if both you and your patient still have time and the inclination, just take a break before continuing.

THE ART OF CLOSING

Closing an initial interview is a minor art form that requires some care. A good closing doesn't just summarize the interview; it also prepares the patient (and you or another clinician) for the sessions that lie ahead. Your patient, who has just invested considerable hope and confidence in the time you have spent together, quite reasonably expects some information to carry away from the encounter. The content of that message will depend in part upon the nature of your relationship.

If you are a practicing clinician responsible for this patient's care, you will probably follow these steps: (1) Summarize your findings; (2) with the patient's collaboration, develop a plan for future management; and (3) set a time for your next meeting. Whenever it is justified, you should also (4) include a message of hope for the future. Here is an example:

> "From what you've told me, it seems that both you and your husband have had a lot of trouble adjusting to the death of your daughter. It's

something you haven't talked much about, and you're suffering from the lack of communication. I think I can help, but before we decide on a plan of action, I'd like to talk with your husband. You said you thought he'd be willing to come in. Could you ask him to make an appointment for next week?"

If you are a trainee, the closing phase of your initial interview might go something like this:

"Thank you for spending so much time with me. You really helped me understand about your type of depression. It sounds as though your therapist is doing everything possible to help. Tomorrow I'd like to ask you more about your family background, if that's all right with you."

You shouldn't expect to anticipate everything the patient needs to hear. In any session as intense as a typical initial interview, you are likely to leave unspoken something that is important to the patient. Therefore, it is usually a good idea to learn whether you've omitted anything that should be covered right away. Before you stop, say something that invites comments or questions about your interview:

"What questions do you have about what we've said so far?" (Note: By assuming that the patient does have questions, you encourage their expression. For some patients, the alternative "Do you have any questions?" might shut down this avenue of communication.)

"Are there any important issues we haven't covered?"

You may find that something you've left out needs action now—such as additional information about proposed treatment, uncertainty as to the time of the next appointment, or reassurance about prognosis. Try to respond factually to any substantive issues.

Of course, you won't be able to cover everything in a single interview session. Most patients will accept this and will be content to delay other concerns, questions, and items of historical information until a subsequent appointment.

Occasionally something comes up right at the end of an interview that would require considerable time to cover adequately. Examples:

"What does the future hold for someone like me?"

"What do you think I should do about my son's alcoholism?"

If neither you nor the patient has any time constraints, you can deal with these questions when they arise. But scheduling conflicts often require that you delay further inquiry until your next interview.

In either case, consider the possible reasons for this new question so late in the interview. Some patients habitually save important information for closing time. Perhaps it takes an entire session to muster the courage to discuss important problems—are they afraid of what you might suggest? Others may find their sessions so valuable that they unconsciously try to prolong them.

You can deal with most of these last-minute items by expressing interest and promising to discuss them during your next session:

> "I'm glad you mentioned that. It's something I want to learn more about. Let's make it our first order of business next time."

If the last-minute information is of life-threatening proportions (suicidal or homicidal ideas), you have no choice but to run overtime. If this happens habitually to you, you should resolve to raise these sensitive topics earlier in your interviews.

QUITTING EARLY

A rare patient may try to break off the interview before you've finished. Usually this will be someone who is exhibiting a personality disorder, a psychosis, intoxication, or extreme stress (perhaps from sleep deprivation or physical illness). Sometimes all of the above apply! Whatever the cause, you suddenly find yourself trying to get information from someone who is putting on a coat to leave. How should you react?

If it is close to the end of the session, point out that you will need just a few more minutes to finish. Then try to accommodate your patient's agitation by selecting only the most important remaining questions to ask.

With a new patient, you don't have much leverage, so try to avoid direct confrontation. If it is early in the interview, especially right at the beginning, the patient may not fully understand the reasons for the interview. Try explaining again. At the same time, you can offer some empathy:

> "I can see that you have been pretty upset. I'm sorry to be adding to your discomfort, but we do need to talk. It's the only way I can get the information I need to help you."

Your appeal to reason may succeed about half the time. If it doesn't, try switching gears to a discussion of the feelings that have blocked cooperation. As before, lead with an empathic statement:

> "You seem pretty uncomfortable. Could you tell me what you are feeling?"

You may learn quite a lot about your patient's fear, anger, or discomfort. By pursuing what you have just heard, you may be able to ease back into the interview.

INTERVIEWER: I can see this has upset you. Could you tell me what you're feeling right now?

PATIENT: *(Rising to leave)* I can't stand it. It's just like the last time!

INTERVIEWER: Were you pretty upset then, too?

PATIENT: You bet I was! You'd be, too, if your therapist treated you the way mine treated me.

INTERVIEWER: It must have made you terribly uncomfortable.

PATIENT: *(Sitting down again)* I was humiliated. And scared.

As in this example, you may hear a good deal about previous attempts at therapy that have gone awry. Be prepared to spend considerable time (both in the initial interview and later) exploring the previous treatment, even though it may have little or nothing to do with the reasons for the current evaluation. (Take care not to criticize or otherwise disparage the previous clinician; your information so far may be pretty one-sided.)

If all your best efforts fail, respect the comfort and privacy of your patient. Specifically, don't plead, threaten, or imply shame or guilt. If your patient gets up to leave the room, avoid physical restraint. Instead, acknowledge the patient's right to make this decision and your intention to respect it. But promise to have another try soon at this important task of gathering information:

"I can see that we'll have to break it off for now. That's OK—you have a right not to be bothered when you're feeling this bad. But it's really important that we figure out what difficulties brought you into the hospital. I can come back this afternoon, after you've had a chance to rest up."

Occasionally *you* may decide to quit early, well short of an hour. This alternative will seem especially attractive when:

- It is late at night, your patient has just been admitted to the hospital, and both of you are exhausted.
- Because of severe psychosis or depression, your patient cannot focus on the interview situation for longer than a few minutes at a time.
- Anger renders your patient unwilling to cooperate.
- You have squeezed a brief interview into an already hectic day. By agreement, you will talk just long enough to discover the major issues and to decide how soon you should meet again.

CHAPTER 15

Interviewing Informants

Most patients can tell you nearly everything you need to know, but you can often enrich your database with third-party information. However, some situations demand that you seek additional information or verification of data from informants. Here are a few of them:

- Children and adolescents often lack adequate perspective on their own behavior.
- Even some adults don't know certain important items of family history.
- Patients with intellectual disability often require help in relating their own information.
- Patients of any age who feel ashamed of past behavior may conceal historical information that you can learn from family or friends. Examples include sexual indiscretions, substance use, suicide attempts, violence, and criminal behavior of any type.
- Patients with psychosis may present delusional interpretations of facts, rather than the facts themselves.
- Childhood health history, often unknown to the patient, can be relevant to intellectual disability or specific learning disorders. For example, there may be a history of obstetrical complications during the birth of patients who have a sporadic form of schizophrenia.
- Patients with cognitive disorders such as Alzheimer's dementia may be unable to give a good history.
- Informants can tell you about cultural norms. This may be the only way to learn that it is normal in your patient's family to believe in astrology or to speak in tongues in church.
- Some patients with personality disorders (especially antisocial personality disorder) do not reliably tell the truth.

- Some personality disorders don't much bother the patients; it's their families and friends who suffer.
- For some, safeguarding a family secret may even be more important than giving you information that could help with diagnosis or treatment.
- Family patterns of interaction can be revealing. For example, high levels of *expressed emotion* (frequent, shouted arguments) in relatives may predict relapse in a patient with schizophrenia who lives with these relatives.
- For obvious reasons, it is unwise to rely solely on self-report in forensic situations.

So whenever possible, I like to obtain information about a patient's present illness from other sources, such as relatives, friends, previous clinical records, and other clinicians. By verifying existing information and providing new facts, you can obtain a clear, comprehensive, balanced view of both patient and milieu.

You will almost always interview the patient first. The only significant exceptions, besides children and younger adolescents who are brought in by their parents, are adults who lack the capacity to speak for themselves. These include regressed patients with schizophrenia, patients with dementia, some individuals with intellectual disability, and persons with whom you do not share a common language. But even when you and your patient communicate well with one another, a little time spent with relatives will usually improve your perspective on the patient's disorder. This is especially true when a relative comes along for the first visit—often a sign of the relative's fear that, without help, the entire story may not be told. Sometimes an insecure patient needs the support of a relative while telling you the reasons for the appointment.

OBTAINING PERMISSION FIRST

Before you talk to friends or relatives, you must usually ask permission from the patient. Most will consent readily. The few who demur may worry that you will let slip something they have been trying to keep secret. You can often quiet these fears by pointing out that your main job is to seek information, not to disperse it, and that to help the most you need another person's perspective. Here's how you might phrase your reassurance:

> "What you've told me is confidential, and I'll respect that confidence. You have that right. But you also have a right to the best help I can give. For that I need to know more about you. That's why I'd like to talk with your wife. She'll naturally want to know what's wrong and

> what we plan to do about it. I think we should tell her, but I'll only say what you and I have already agreed upon. I won't tell her about anything else we've discussed, unless you give me permission in advance."

Once you have reached such an agreement, be scrupulously careful not to divulge additional information. Revealed secrets have an uncanny way of identifying their source. On the rare occasion when you are denied permission, you might suggest that the patient sit in when you talk to the friend or relative. This will address any fears that you might use the meeting to hatch some sort of plot behind the patient's back.

As a rule, though, you should try to interview the informant when the patient is not present. The privacy will improve your chances for obtaining complete, accurate information, and both you and the informant will feel more comfortable.

There are only a few significant exceptions to the requirement to obtain the patient's consent first. These include patients who are:

Minors (though you should strive for their consent, too)

On conservatorship or unable to give consent

Violent

Mute

Acutely suicidal

Experiencing any other acute medical or mental health emergency

Then, when it is clear that a patient does not have the judgment to exercise autonomy, it is your duty to step in and make a decision as to the best course of action. To accomplish this, you will usually obtain information in any way you can.

What about the friend or relative who calls with information and requests that you withhold it from the patient, or at least that you not reveal its source? To give such a promise makes you complicit in weaving a tangled web—a situation I would try to avoid. To be sure, there's no point in creating problems by blabbing stuff needlessly. But you can drive yourself nuts trying to keep straight whom you've promised to keep what secret from whom.

CHOOSING AN INFORMANT

Because your goal is to obtain as much pertinent material as you can, you will naturally choose an informant who knows your patient well. A spouse or partner usually has the most up-to-date information, so if the patient is married or has an intimate relationship of long standing, this is

the person you will probably speak with first. But the sort of information you need may dictate a different choice. For example, if you want to know about childhood hyperactivity, you should interview a parent. Another consideration: Studies show that relatives who have had an illness similar to the patient's are better able to recognize its symptoms—probably because they've been sensitized to the symptoms and course of illness. Finally, as we'll discuss later, yours could end up being a group interview with several relatives, friends, and even co-workers or spiritual counselors.

WHAT DO YOU ASK?

You should start by briefly explaining the purpose of this interview. Relatives will readily accept that you need to verify history or to give them information. But they may worry that as a clinician you have another agenda, such as blaming them or asking them to assume increased responsibility for the patient.

Your earlier interview with the patient should have netted a rich knowledge base, so your discussion with informants can usually be comparatively brief—perhaps just a few minutes to half an hour. Even if you think you know exactly what questions you want answered, you could be surprised with new information about a problem you hadn't recognized before. So, to learn what the informant knows, begin with a brief fishing expedition. Use an open-ended question as bait.

In the example that follows, the patient had spent much of the initial interview talking about her previous episodes of depression. So when her husband came in, the interviewer was ready with questions about depressive symptoms, treatment, and response. Fortunately, the first question was open-ended.

> INTERVIEWER: What can you tell me about your wife's difficulty?
>
> PATIENT'S HUSBAND: Well, I just hope you can do something about her drinking. She's drunk nearly every afternoon when I get home from work, but she refuses to admit she's got a problem.

Once you've determined that the patient and informant(s) identify the same set of problems, you can get down to the business of obtaining the additional specific information you need. It will be of two sorts: (1) questions the patient was unable to answer; and (2) items about which there is some confusion in your mind, often due to inconsistency in the patient's story. Here are a few examples of each:

History of mental illness in a parent

The patient's own developmental history

A reappraisal of your patient's substance use history

The patient's symptoms during a psychotic illness

The ability of a patient to provide self-care

Relatives' willingness to provide support after discharge from hospital

A spouse's view of the reasons behind marital discord

Behavior that suggests a possible criminal career

An appraisal of the patient's personality characteristics

The patient's adherence to treatment

Effects on the family of any change in behavior

Even if you don't learn much that is new about the patient, an open-ended session with an informant may help you learn the answers to these questions:

How well does the family understand the illness?

What has the patient told the informant about the symptoms?

How is this person now, as compared to when last fully functioning?

How has your patient interpreted the facts?

Has the patient distorted what you have said?

If the information from an informant conflicts with what you have obtained from your patient, you must decide which story to believe (if either). You are by no means safe if you automatically accept the informant's version; status as a mental health patient shouldn't automatically discredit anyone's testimony. Rather, when you evaluate conflicting stories, weigh the following factors for each informant, including the patient:

How much contact has the informant had with the patient?

How much does the informant appear to remember?

Does the informant seem to be protecting someone (self, patient, or others)?

Does family taboo appear to prevent the informant from discussing sensitive material?

How much is the story being distorted by wishful thinking (for example, the imagined happiness of a faltering marriage)?

Is there evidence of a "halo effect" that puts a spin (positive or negative) on all the patient's behavior?

Does your informant seem motivated to give you a complete and accurate story?

Afterward, it's a good idea to discuss the session with your patient. You should relate some idea of what was said, so as to provide reassurance that you have broken no confidences, but how specific or general you will be depends on your patient's needs and your own taste. You should also take care not to break any confidences from the relatives.

Here is an example of the sort of feedback you might give your patient:

> "I had a very good talk with your wife, Mr. Crenshaw. Her information confirmed what you told me last week about your depression, and I think we all see eye to eye on the need for treatment. As you requested, I didn't say anything to her about the cocaine use, but I do think you'll feel better once you've gotten up the nerve to discuss it with her yourself."

GROUP INTERVIEWS

If the patient's family is large and many members live nearby, you may find yourself interviewing the whole clan. Some clinicians find this difficult, especially when the family members are unhappy and express themselves forcefully. Although it can be difficult to manage a large group of relatives, there are advantages to this approach.

- It is far more efficient than trying to talk with them individually. Although you might sometimes get the family to agree on one spokesperson with whom you will meet, information can be lost or distorted as it is passed down the line.
- The family is an important part of your patient's environment. A group interview gives you the chance to observe how the relatives interact with one another and, by logical inference, with the patient. Do they treat one another considerately? Do you detect accusations, scapegoating, or guilt in one or more of your informants? Is their concern generally for the patient or for their own comfort?
- In some cases, you may elect to interview family and patient together. This obviates all problems with confidentiality, because all hear what each person says. It also gives you the chance to observe directly how the patient and family interact. Do relatives ignore or answer for the patient? Do they disagree a lot? Shout? Fight?
- If you determine that family dynamics contribute in part to your patient's difficulties, meeting with everyone can help lay the groundwork for eventual change in the home milieu, as an adjunct to therapy.
- You could establish the basis for later family therapy, if it seems that this might be a useful approach to your patient's difficulties.

When you are meeting with more than one informant at a time, be sure to encourage all relatives to have their say. Often someone will be passive and silent; this is the individual you should try to draw out. It is better to have everyone's input at the beginning, rather than leaving them to sort out their perspectives later, when you're not around to help. You shouldn't make decisions for them, and you shouldn't take sides. Your goal should be to facilitate the discussion so that all family members can understand the patient and their common problems. But above all, you must keep to yourself information that the patient would wish to keep private.

OTHER INTERVIEW SETTINGS

Telephone Calls

Several studies have shown that you can obtain good-quality information from telephone interviews—perhaps not quite as robust as data from interviews conducted face-to-face, but far better than written questionnaires. Especially if there's no other way to speak with a relative, it is certainly better than nothing. But it can be a challenge to interview someone for the first time without face-to-face contact. If you must rely on words and tone of voice alone, you can't extract the nuances of meaning that body language so readily conveys. Furthermore, unless you are participating in a video conference call, on the telephone relatives cannot size *you* up.

In recent years, Internet-based services such as Skype and FaceTime have made video calling much more common. Even so, a personal interview can so much better convey the warm feelings that allow relatives to know that you are someone they can trust with secret or sensitive information. Finally, consider confidentiality laws. Without visual contact, it is more difficult to be sure whom you are speaking with. If you give out information to someone you think is a spouse, but is actually an employer, you could harm both your patient's career and your own reputation.

House Calls

Although the house call has generally gone the way of insulin coma therapy, it can still be a useful tool for the clinician who wants maximum information about all aspects of a patient's milieu. There you can get a feeling for the environment (type of dwelling, neighborhood) and the family members, who, when relaxed at home, may behave more "normally" than in an office or hospital setting.

CHAPTER 16

Meeting Resistance

In most interviews, two individuals work together to achieve a common understanding. The vast majority of patients will be cooperative, knowledgeable, and (to one degree or other) insightful. But all patients have personal agendas, and sometimes these conflict with the usual goals of the initial interview. That's why many patients will in some manner resist giving complete information. The result can be behavior that frustrates your attempts to obtain a complete database while building rapport.

Resistance is any conscious or unconscious attempt to avoid a topic of discussion. Because nearly everyone feels uncomfortable with certain topics, resistance is perhaps the most frequent problem behavior clinicians must learn to deal with. For a number of reasons, then, it is important to address resistance when it appears, rather than simply moving on without trying to determine (and remedy) its causes.

RECOGNIZING RESISTANCE

To counter resistance, you must first recognize it. Sometimes this is easy, especially if it takes the form of such an obvious statement as "I'd rather not talk about that." But many patients feel uncomfortable with open defiance; they may resist you in ways so subtle that you will be hard-pressed to detect them. Watch for any of these behaviors that could indicate that your interview may be in trouble:

Tardiness. Being late for the interview is a classic sign of resistance. It is perhaps less common during an initial interview than during subsequent ones.

Voluntary behaviors. Poor eye contact, glancing at the clock, answering a cell phone or pager, or shifting uneasily while seated suggests that your patient may feel uncomfortable with the topic currently under discussion.

Involuntary behaviors. Flushing, yawning, or swallowing can imply discomfort. The blank stare of a patient with PTSD experiencing a flashback falls somewhere between voluntary and involuntary behavior.

Forgetfulness. Some patients develop a "convenient" poor memory and respond to certain questions with "I don't know" or "I can't remember."

Omissions. The patient leaves out certain information. Unless reliable informants are consulted, even experienced clinicians have trouble detecting this sort of resistance. "I don't have any problems" may be an overt attempt to bury issues that should be exhumed.

Contradictions. Information that contradicts what you thought you learned earlier is relatively easy to spot but may be difficult to reconcile.

Changing the subject. Shifting to another topic of conversation may be an attempt to draw you away from a subject the patient would like to avoid. For example, you ask Mr. Blocker how he feels about his impending divorce; he responds by telling you that his wife's attorney has been bleeding him dry.

Exaggerations. Puffing up their own accomplishments is one way some people avoid facing the truth about themselves. Perhaps you can't detect an individual exaggeration, but with time you may begin to discern a pattern of improbable claims.

Diversionary tactics. These include telling jokes and asking to get a drink or to use the bathroom. Some patients may try to control the interview by asking about the interviewer's personal life.

Silence. This can be a major indicator of resistance. It should not be confused with the time some patients need to think before responding to a complicated question.

A slight hesitation. Most subtle of all may be just a slight hesitation before answering certain questions.

WHY DO PATIENTS RESIST?

Patients may resist telling the whole story to a clinician for a variety of reasons. Understanding these reasons can provide the key to breaking up the resistance.

• Probably one of the most common reasons is preventing embarrassment, which may operate especially during an initial interview. This is certainly understandable: Baring your soul to a total stranger is the unnatural antithesis of self-protection. It can be especially hard to reveal sensitive material about sex, illegal activities, and any behavior that demonstrates a lapse of judgment.

• Some patients (or their families) fear criticism or worry that you may be shocked by their stories. They have learned to avoid disapproval simply by not risking it: They keep private material they consider blameworthy.

• Some patients may withhold information because they are too afraid of its implications for diagnosis, prognosis, or treatment. The stigma of mental illness—perhaps being thought "crazy"—is one example.

• Your new patient might not yet feel enough trust to communicate fully with you, especially about thoughts or behavior that could damage an intimate relationship or jeopardize a job or legal status. Unhappily, a previous experience may have instigated the fear that a mental health professional might violate confidentiality.

• Altruism may motivate a patient to protect a friend or loved one from any of the consequences mentioned previously.

• Some incidents or thoughts may seem too trivial to relate.

• The patient could be testing you (consciously or not) to see whether you are smart enough or persistent enough (do you care enough?) to dig out the information that is being withheld.

• Patients may withhold information out of conscious or unconscious anger—an emotion that could have any of a number of causes. You may have unintentionally said something upsetting, or the patient may be reenacting with you feelings held for someone else in the past; such behavior is called *transference*. Of course, transference is by no means limited to feelings of anger.

Whatever the cause, you must not allow resistance to persist unexplored and unchallenged. You must try to determine the cause and to remedy it. It can be a serious error to skip important topics or just passively to follow the patient's lead.

HOW TO COPE WITH RESISTANCE

Above all else, it is most important that you try to understand (and remedy, if you can) the reasons behind the behavior. The first step should be

to consider whether you have done anything to provoke the resistance. There may be something obvious that you can deal with directly.

INTERVIEWER: I notice that you seem to have grown quiet all of a sudden. What seems to be the problem?

PATIENT: Oh, I don't know.

INTERVIEWER: I'm wondering if you're upset that I said I wanted to talk to your husband.

PATIENT: *(Long pause)* Well, I don't understand why you want to.

INTERVIEWER: Could you tell me what you're afraid of?

PATIENT: He wouldn't understand about that affair I told you about. He isn't a bit broad-minded.

INTERVIEWER: Ah, I can see why you're unhappy. I think anyone would be, who was worried that her therapist might break a confidence like that one. But that wasn't what I had in mind. The reason I want to talk to him is to learn how he views the marital problems you two are having. I think it would help me to understand the whole picture better. Do you think that you could ask him to join you during your next appointment?

This clinician's explanation told the patient several things: (1) that the clinician understood her, (2) that she had a right to her feelings, (3) that her fears were groundless, and (4) that she would be present during the interview with her husband.

All too often, however, you will be unable to identify anything specific that can be quickly corrected. Then the approach you take will depend on several features of the resistance itself:

Its cause

Its severity

The form it takes

The importance of the information you are seeking

Managing Silence

A common example of mild resistance is the embarrassed silence. You may encounter this reaction to questions about sex (see Chapter 9), but it could occur in nearly any interview situation. Your best first response may be a little silence of your own. You might try glancing away for a few seconds to emphasize your willingness to wait. By saying nothing for a few moments, you give your patient some extra thinking time. Maybe that's all

the silence signified in the first place. But if instead it's early resistance, you allow the patient time to try to resolve the conflict.

However, a prolonged lack of response may establish a precedent for withholding further information later in the interview, and that is not in the patient's best interests. If a decent interval (no more than 10–15 seconds) fails to elicit a response, you should probably intervene.

During the brief silence, your patient's thoughts may have wandered, so your next step should be to refocus the question by asking it again in a slightly different form. From the top, here's a brief example:

INTERVIEWER: How has your sexual adjustment been?

PATIENT: *(Silently looks at the floor for 15 seconds.)*

INTERVIEWER: I was wondering whether there had been any problems with your sex life.

If the question seems important (the patient's inability to answer suggests that it might be), you should probably persevere. Start by giving the patient control over what will be said and by offering reassurance.

INTERVIEWER: Tell me what you feel comfortable saying about your sex life.

PATIENT: This is really hard for me.

INTERVIEWER: I understand that. But it's important, and it's safe to talk about it here.

Another tactic combines multiple approaches. You might word it something like this:

"A lot of people have difficulty with sensitive issues like this one. I'm really sorry that I have to put you through this, but to help you most, I need all the information I can possibly get. Please try to help me."

In this single speech you have (1) expressed sympathy, (2) underscored the normality of your patient's feelings, (3) reemphasized the importance of obtaining a complete database, and (4) issued a personal appeal for the patient's assistance.

Yet another approach is to try to name the emotions your patient might be having. If you do so correctly, you will enhance your image as an empathetic, perceptive interviewer who can be trusted with secrets. You will maximize your chances of success if you name several possible emotions, as in this example:

"I can see you are having a real problem with that question. Sometimes people have trouble with questions when they feel ashamed. Or sometimes it's anxiety or fear. Are you having any of those feelings now?"

Although you have now asked something that is different from your original question, the two are related. Your patient may be able to respond more readily to the second one. And notice that you've greatly increased your chances of guessing the right emotion by offering up several possible negative emotions.

You want to reinforce in your patient the habit of responding to you, and even a gesture is better than nothing at all. Once you have obtained any response, even a silent shrug or frown, you can often parlay it into a renewal of speech.

INTERVIEWER: You must be feeling pretty upset about this. Am I right?

PATIENT: *(Nods.)*

INTERVIEWER: I think maybe we should move on and talk about your education instead. Does that seem like a good idea to you?

PATIENT: *(Nods.)*

INTERVIEWER: Is that something you think you can talk about?

PATIENT: Yes . . . I think so.

INTERVIEWER: That other subject is pretty important, but this clearly isn't the time to talk about it. We'll come back to it later.

Delaying the discussion of difficult material, as in the example just given, is probably one of the most often used methods of dealing with moderate to severe resistance. The technique sacrifices information for the sake of rapport and the integrity of the interview, so you should use it sparingly. It is important for the patient to understand that the matter isn't closed, only postponed. That was the intent of this interviewer's promise to revisit the question later.

An answer of "I don't know" gives you no more information than does dead silence; if repeated often, it can cause an interview to grind to a halt. Occasionally, you might succeed in getting the patient off dead center by responding:

"Well, what do you think about it?"

Unfortunately, often this only elicits the obvious (and maddening) rejoinder, "I don't know."

If you're not getting much information anyway, you won't take a big risk by forcing a rare confrontation. You may get some clues as to the reason for the resistance. In this example the patient confronted is Julie, a 16-year-old girl:

INTERVIEWER: *(Leans forward and smiles.)* Several times when you've said, "I don't know," it's been about questions that I think you do know the answer to. What do you think might happen if you didn't hold back?

JULIE: I don't know.

INTERVIEWER: A lot of people don't like to talk because they're upset about something. Have you been feeling upset?

JULIE: Maybe.

INTERVIEWER: *(Smiles.)* Maybe we should try to understand that. What were you feeling just a moment ago?

JULIE: My dumb mother made me come. *(Pauses.)*

INTERVIEWER: So it was your mom's idea to come?

This example demonstrates confrontation and naming of feelings, which have already been mentioned. It also suggests several other techniques that can help break through resistance:

- Focus on describing the symptoms; just for now, don't worry about what they might mean.

- Switch from facts to feelings. Resistance usually has an emotional basis. This interviewer recognized that feelings had to be explored before getting on with the history taking.

- Emphasize the normal. Patients sometimes conclude that they must be pretty bizarre, just to be under the care of a mental health clinician. Julie may have felt better once she learned that her clinician had encountered this behavior before and didn't find it strange.

- Reject the behavior; accept the person. By leaning forward and using warm words and a friendly tone of voice, Julie's interviewer clearly indicated both (1) unconditional acceptance of the patient as a person and (2) the desirability of a different response.

- Use both verbal and nonverbal encouragements. Once the patient began to speak, the interviewer encouraged further efforts with a smile and by making a suggestion that took off from her "Maybe."

- Praise the patient for giving a response. Other encouragements (nods, paraphrasing) have been discussed in Chapter 4.

- Focus on the patient's interests. As soon as it became clear that this patient resented being forced to come, the interviewer shifted the focus to her relationship with her mother. Subsequently, the session became much more productive.

- Still another technique is to look for a less affect-laden model of the behavior or feelings in question, and discuss the model first. Often this is a similar episode that happened to the patient long ago, but it could be one that affected a friend or relative. Here's how the process works:

> INTERVIEWER: Have you been feeling so bad you've thought about harming yourself?
>
> PATIENT: I—I can't say.
>
> INTERVIEWER: It's a pretty upsetting subject, isn't it?
>
> PATIENT: *(Nods.)*
>
> INTERVIEWER: Didn't you say you made a suicide attempt several years ago?
>
> PATIENT: Yes. *(Long pause)*
>
> INTERVIEWER: What happened then?
>
> PATIENT: I overdosed on my wife's heart tablets. But I threw them all up.
>
> INTERVIEWER: You must have been feeling pretty desperate.
>
> PATIENT: *(Nods.)*
>
> INTERVIEWER: Are you feeling that way now?
>
> PATIENT: I guess so. But I don't like to talk about it. It scares my wife.

With variations, this technique can sometimes ease you into a fruitful discussion after a more direct approach has failed. But if the only result is more resistance, you should probably change topics completely—as long as the delay doesn't pose possible danger to the patient.

Sometimes patients themselves will spontaneously adopt this technique of changing to a less affect-laden model. When that happens, hear out the past example, then ask:

> "Can you see any connection between what happened then and the way you have been behaving just recently?"

Most patients will see the point. For those who do not, you can gently draw the parallel yourself.

Tardiness

With only one incident in your sample, you don't know whether lateness is going to be a chronic problem. If the patient is late to the first interview,

and if you have more time available, it wouldn't be amiss to run long and complete your evaluation. If not, your best option is to say, "Let's make the best use of the time we have," and get right to work.

But the patient who is often late to appointments is the bane of many a mental health practice. If it only happened once or twice, you could perhaps ignore it. Some people are habitually late everywhere, but it isn't especially useful to accept that as a reason; chronic tardiness gets in the way of more than just mental health care. I don't recommend giving additional time to someone who is always late: It sends the message that it's OK not to fulfill personal obligations, and it unfairly penalizes the patient who has the next appointment. Here is behavior you have to deal with as resistance.

First, make sure the patient doesn't think that you are offended. And you shouldn't be: It isn't about you; it's about your patient's problem (perhaps the very one that prompted treatment in the first place). Rather, your words and your demeanor should say, "I'm concerned that you aren't getting the help you need." Invite the patient to explore with you the possible reasons—"What are you afraid might come up during our session?"—but then focus your efforts on correcting the behavior: "What can you think of to help get yourself here on time?" You'll probably find yourself discussing the use of alarm clocks and reminders the patient can get from dozens of free apps for smart phones.

Special Techniques

Several other interview techniques are sometimes useful in countering resistance. For the most part, these strategies apply in specific situations or to particular types of patients. Novice interviewers will rarely use these specialized techniques.

- Offer an excuse for unfavorable information. By helping out with plausible reasons, you may encourage your patient to be frank about embarrassing or distressing problems.

  INTERVIEWER: How much have you been drinking just recently?

  PATIENT: Not much. I really don't keep track.

  INTERVIEWER: What with all the stress surrounding your husband's death, I thought you might have started drinking heavily again, like what happened several years ago when your mother died.

  PATIENT: You're right. I've been so overwhelmed. If I didn't have three or four doubles every evening, I wouldn't be able to get to sleep at all.

- Exaggerate negative consequences that *didn't* happen. By emphasizing the worst possible outcome of a behavior, you diminish the patient's anxiety about what actually did happen.

INTERVIEWER: During that fight, did you really hurt your wife?

PATIENT: Well . . . *(Silence)*

INTERVIEWER: Well, did you kill her?

PATIENT: Nah, I just knocked her around a little bit.

- Induce your patient to brag. Rarely, a patient withholds information about an exploit but seems secretly proud of it. Some interviewers try to encourage frankness by subtly implying admiration for some aspect of the behavior in question.

INTERVIEWER: How much were you drinking then?

PATIENT: Gee, that's hard to say.

INTERVIEWER: You're a pretty good-sized man. You look like you could really put it away.

PATIENT: I've hoisted a few in my day.

INTERVIEWER: I'll bet you could drink them all under the table!

PATIENT: Yeah, I suppose I've won my share of chug-a-lug contests.

This technique can build rapport while it obtains information. Although it is probably innocuous enough when applied to substance use, I worry that it might send a message of approval to a patient with a personality disorder whose activities include sexual misconduct, fighting, or criminal behavior. If you ever use this technique, be careful not to condone or encourage the behavior itself. Quite frankly, I've hardly ever used it.

PREVENTION

As with any other problem, no remedy for resistance is as satisfactory as preventing it in the first place. The following strategies should help you avoid having to use the more devious techniques we have just discussed.

- If before the interview begins you can obtain information about your patient's character or style of interacting, you may be better able to modify your approach to difficult topics. Resources include word-of-mouth information from referring clinicians and records from previous hospitalizations.

- Sometimes you can tell right away that your patient is reluctant to talk. A scowl, a sigh, or an upturned gaze may tip you off, even before *you* begin to speak. If so, perhaps this is the time to break my Chapter 1 rule and start with small talk. A few moments of conversation about something you share (the weather or sporting interests) might help identify you as "friendly" and reduce your patient's antagonism. The purpose of

small talk—to grease the skids for productive conversation with a potentially difficult patient—suggests two warnings: (1) Politics and religion are never "small" topics; shun them like a dirty needle. (2) For any subject, avoid taking a position that might be considered strong or controversial. It could throw you into confrontation that your already challenging interview hardly needs.

- Carefully monitor your reactions to the information you obtain. If your speech or facial expression hints of surprise or disapproval, you may seriously damage rapport and limit both the quantity and quality of your information.

- Answer questions as completely and honestly as you can. Of course, this is the obvious approach to take with any patient, but your open, careful discussions of your intentions and the possible benefits of cooperation might especially help reduce the suspicions of someone who is paranoid or even psychotic.

- Individualize your history-taking technique. Some patients simply won't be hurried. They aren't psychotic or demented; they simply have to tell their stories in their own way. When you encounter such a patient, you might as well forget about your time schedule, relax, and enjoy the ride. You'll get your history—a little at a time—and you'll preserve rapport.

- Preface your MSE questions about delusions, hallucinations, and orientation with the remark that these "routine questions" are part of your usual thorough evaluation. This should help to defuse any concern that you suspect your patient of being mentally slow or psychotic.

- If you encounter psychotic material such as delusions or hallucinations, don't argue. You won't win points by refuting what your patient "knows" to be true. But neither should you agree with something you know is false: You don't want to reinforce the psychosis. Instead, ask how long the patient has felt that way, or emphasize your concern for the accompanying discomfort. For example, the patient may be frightened by the content of the hallucination.

YOUR ATTITUDE

As noted earlier, with every patient it is important to understand your own feelings. If you find you are feeling bored, angry, or disgusted, ask yourself, "Why?" Is there someone this patient reminds you of, such as a supervisor, parent, or spouse? (When a therapist's feelings toward patients are carried over from personal relationships, we call it *countertransference*.) Perhaps some features of this patient's personality remind you of some

of your own less admirable traits. Do you have anxiety about your own health, marriage, or family? These feelings are ubiquitous, so even experienced clinicians must work to prevent their intrusion into therapeutic relationships.

A patient who is uncooperative or difficult in other ways creates a special challenge. As a clinician, you must not let passive–aggressive behavior, sarcasm, or anger precipitate an outburst from you. Such negative affect, especially when it comes early in the relationship, can imperil an interview and seriously damage future rapport. If you find yourself feeling uncomfortable during an interview, ask yourself:

"Why am I feeling so upset?"

"What message am I missing?"

"Whom does this patient remind me of?"

The answers to these questions should help you determine what corrective action to take.

CHAPTER 17

Special or Challenging Patient Behaviors and Issues

All patients are special, and each is unique. But the behaviors of some can be especially challenging: They may be vague, hostile, untruthful, confused, or even violent. And other than behaviors, certain patient characteristics (for example, physical attributes) may also require thoughtful attention. Challenging behaviors and issues offer us the opportunity to hone our skills of accommodation and persuasion, and to practice the virtues of patience and tolerance.

VAGUENESS

Instead of information, a patient may give you only empty words. Here are a few examples:

The unfocused chief complaint. A variety of concerns may be stated, but none of them seems an adequate reason for seeking treatment.

Overgeneralization. A single episode of illness may be treated as typical when it is not; one example of a friend's behavior is labeled as "usual." The words *always* and *never* may tip you off to overgeneralization.

Approximate answers. Often this means that the patient gives you adjectives when you want numbers.

INTERVIEWER: How long have you been drinking?

PATIENT: A long time.

INTERVIEWER: Can you give me an idea of how long?

PATIENT: Well, quite a while.

Sometimes a patient simply seems unable to give precise descriptors.

INTERVIEWER: How did you feel when your stepdaughter arrived for that long visit?

PATIENT: Lousy.

INTERVIEWER: Well, can you describe your feelings then?

PATIENT: I felt terrible.

Dealing with Vagueness

Try first to determine why the patient is being vague. In some cases, it may be a function of the patient's particular mental disorder: Vague speech is especially characteristic of patients who have intellectual disability, psychosis, or personality disorders. However, you could encounter it in almost anyone who is unaccustomed to thinking in precise terms. Perhaps this is the first time your patient has tried to express troubling feelings. It may also indicate resistance to the interview—is this person trying to hide something?

As you might imagine, it won't help to point out that the patient is being "unclear." If you have to label the behavior, try "overgeneralizing." You can ask, "Help me to understand." You can also deal with vagueness by providing structure: Indicate clearly what type of answer or degree of precision you expect.

INTERVIEWER: How much time did you serve in the penitentiary?

PATIENT: Oh, quite a while.

INTERVIEWER: How long was that in months or years?

To the patient who persists in using a general description such as *terrible*, you might respond:

"What is your interpretation of *terrible*?"

"Could you give me an example of what you mean by *terrible*?"

You may have to pin down some patients with specific questions, perhaps based on the areas of clinical interest (see Chapter 13) or on what you know about specific mental disorders.

INTERVIEWER: What do you mean by *terrible*?

PATIENT: I don't know. I just felt bad.

INTERVIEWER: Can you give me an example?

PATIENT: *(Pauses.)* Just really awful.

INTERVIEWER: Well, were you depressed?

PATIENT: Sometimes.

INTERVIEWER: Did you feel anxiety?

PATIENT: Yeah, that's it! I was wound up like a clock!

Whatever technique you use, once you have clarified your patient's meaning, summarize to be sure you have understood:

> "So when you said you 'felt terrible' when your stepdaughter arrived for a visit, you were a little depressed, but mainly you felt this sense of overwhelming anxiety."

It may require a lot of prompting to teach the habit of precision to a patient who prefers approximate answers. You could find yourself resorting to multiple-choice questions. Early in the interview, an unfocused, rambling patient may require you to use focused, short-answer questions. If the vagueness persists despite your best efforts, suspect some source of underlying resistance. To explore the reasons for this resistance, you might have to risk a confrontation. Try:

> "In order to help you, I really need a more definite answer. Is there some reason you are having trouble answering my questions?"

Inability to Generalize

A problem related to vagueness is that some patients cannot generalize experiences. When you ask them to give you a broad picture, they respond with specific examples and tiny vignettes.

You can try to deal with this by redefining what it is you are after. Using words like *common*, *often*, and *usually* may help you teach your patient what you want.

INTERVIEWER: Do you have a lot of trouble dealing with anger?

PATIENT: Last week I got really burned at my mother-in-law. I threw a fit.

INTERVIEWER: Here's what I'd like to know: Is this pretty common for you?

If your patient simply cannot generalize, you may have to make do with several examples from which you distill the generalization yourself. Then summarize aloud to make sure that you've got it right.

LYING

As a part of the therapeutic contract implicit in any clinical relationship, the patient agrees to tell the truth. At the beginning of your work with any patient, you should assume that this will be the case. Unfortunately, for a variety of reasons, it doesn't always turn out this way.

Patients may lie when they are frightened, ashamed, worried, or angry. These emotions probably apply to most people who seek the help of mental health professionals; heck, don't they actually affect each of us to a degree? Other patients may lie for social gain—to get or keep a job, to avoid punishment, or to feel more respected. Some may just have trouble resolving the inherent conflict between reporting accurately and saving face. Those who habitually lie without discernible cause or benefit, popularly termed "pathological [or compulsive] liars," probably constitute a small minority.

A variety of clues could warn you that your patient might not be telling the truth:

- The history is inconsistent with the known course of the disorder you suspect. For example, your patient denies ever being hospitalized, despite a long history of severe manic symptoms.

- You ask about any behavior that would make most people feel ashamed or guilty. Common examples include drug use, sexual issues, suicidal behavior, and violence—any of which could provide an incentive for shading the truth.

- The patient tells a story that is internally inconsistent. An extreme example: Someone who never graduated from the eighth grade claims to have held high-level executive positions.

- You notice some of the behaviors that have been associated with lying. These can include shifting gaze with poor eye contact, yawning, stammering, sweating, hyperventilating, motor restlessness or fidgeting, flushing, raised vocal pitch, rapid speech, and a delay during which the patient seems to be trying to determine what answer sounds best. Because any of these behaviors can have other causes, you shouldn't leap to conclusions. Rather, try to confirm your suspicions with further observation or from informants.

- You suspect a severe personality disorder. For example, a childhood history of delinquency progressing to adult criminality would make you suspect antisocial personality disorder. These patients often display little regard for the truth.

- Despite ample opportunity and objective justification, your patient denies all negative personal attributes. For example:

  > An embittered 40-year-old woman is a college graduate stuck in a dull secretarial position. Her life has apparently been loveless and friendless. But when you ask her what she would change about herself if she had it to do over again, she replies, "Nothing."

- Your patient seems to exaggerate lifetime accomplishments.

Dealing with Lying

As with other problematic behaviors, dealing with suspected lying requires a delicate touch. You need accurate information to make a diagnosis, but open confrontation risks early rupture of the relationship. (In ongoing therapy, you would eventually have to discuss the need for trust in your relationship. Although treatment is not the principal goal of the initial interview, neither do you want to say anything that will impede your later ability to work constructively with your patient.)

Before settling on any course of action, it is often worthwhile to ask for a restatement of what your patient just said:

> "Could you run that by me again?"

Perhaps you misunderstood; perhaps the patient misspoke; in any case, added details could clarify the issue.

Another obvious approach is to ignore the lie and seek the truth elsewhere—from records or informants, for example. You may be able to arrive at the truth by piecing together a careful, year-by-year history of work, education, and social activities. Although it takes time, I've always found life history detective work to be interesting and rewarding.

Should you conclude that a confrontation over the issue of misinformation is warranted, formulate your questions in a way that avoids making accusations. Rather, couch them in terms of resolving a misunderstanding or clearing up your own confusion:

> "Something puzzles me. You just said that you hadn't had any problems with drinking, but your health care record here mentions two emergency room visits in the past year for intoxication. Can you help me out with that?"

To someone whose response indicates a willingness to fight ("You calling me a liar?"), you can answer that your problem isn't with the patient but with the story:

"Help me to understand some of the contradictions."

Something of the same approach—a gentle request to help you understand—may successfully address the related behaviors of exaggeration and minimizing symptoms.

And, always, if you suspect that the patient is being deceitful or is (to use a word I try to avoid) malingering, be extra careful not to ask leading questions. It is bad enough when a patient introduces false notes into the conversation. It is far worse when the interviewer assists in the deceit.

HOSTILITY

Of all the problem behaviors, hostility—anger or antagonism, usually directed toward someone—may be the easiest to spot. The patient's feelings are clearly shown in a scowl, clenched fist, angry tone of voice, or sarcastic content of speech. Even those patients who resolutely smile despite their negative emotions may betray their underlying feelings by a set of the jaw or by vocal tension. Whatever its manifestations, hostility must be dealt with immediately and effectively. To do less jeopardizes your entire interview.

The possible causes of hostility are numerous. Here are a few, some of which have already been mentioned as causing other problem behaviors:

Fear of illness. These patients reject the notion that they are ill by rejecting their need for a caregiver.

Displaced emotion. Perhaps it isn't you or the present situation, but a boss, spouse, or previous mental health professional who lies behind the hostility. You become the innocent target of negative transference.

Fear of intimacy. This reason may be especially relevant in a mental health interview, where hostility serves to "protect" the patient from making unwanted revelations.

Hidden feelings. A person who vents anger may do it to cover up another emotion that is even more frightening—anxiety, perhaps, or depression.

Fear of dependence. Some patients resent having to seek help for any problem. For them, hostility may be a mechanism for keeping a safe distance from people they view as wielding power. Perhaps this stems from long experience of feeling socially inferior.

Habit. Whatever the initial cause, some people have become habitually aggressive and hostile, which helps them maintain control over others.

Apparent lack of interviewer empathy. In addition to the foregoing "patient-centered" causes, consider the effect of an interviewer who appears uninvolved or uninterested. Most mental health patients already bear a considerable burden of negative emotions. If they must also cope with someone who is supposed to behave therapeutically, yet comes across as cold or unempathic, the natural reaction might well be added hostility.

You might consider this last possibility if hostility frequently affects your relationships with patients. In such a case, you should probably obtain diagnostic help, perhaps from a supervisor or faculty member where you trained. Ask this person to review video sessions of you interviewing patients. A pattern of recurring anger or hostility should be apparent to anyone expert in the art of the interview. It would require more remediation than can be found in any book.

Handling Hostility

Negative emotions usually make their owners feel uncomfortable; hostility makes friends and acquaintances feel that way, too. Because this reactive discomfort also applies to mental health interviewers, your first impulse may be to change the subject quickly. That strategy could succeed if the problem is anger or resentment stirred up by your line of questioning. But true hostility tends to be generalized more than anger; you're unlikely to deal with it successfully by ignoring it.

Any evidence of hostility warns you that before continuing, you must confront your patient's feelings. To advance your interview effectively, you must make the confrontation nonthreatening and nonjudgmental. Here's how you might accomplish it:

INTERVIEWER: Why did you come here?

PATIENT [a tall, heavy-set, 28-year-old man]: Why was I brought here, you mean? And why should I tell you? You're the third one I've talked with this afternoon!

INTERVIEWER: I'll bet you're getting sick of talking about it. I don't blame you.

PATIENT: You don't blame me; you just bug me.

INTERVIEWER: I don't mean to bother you. I can see that anyone as upset as you are must have a lot on his mind.

PATIENT: You've got that right.

INTERVIEWER: What is it? It must be pretty awful to get you this stirred up.

PATIENT: It's that, all right. *(Pauses.)* My wife left me.

Although this patient's angry words were directed toward the interviewer, the underlying reason for the hostility was much more personal. By excusing the behavior and sympathizing with the feelings, the interviewer could side with the patient and break through to the core of his hostility. Responding to the fear behind the hostility is often an excellent counter to hostility. Notice how this interviewer also drew the patient away from invective and into conversation by requesting details.

Different reactions from the interviewer would probably only have produced additional negative feelings:

"Look, I'm only trying to help you." (Guilt)

"If you don't talk about it, you'll never get over it." (Anxiety)

"Don't bark at me! I haven't done anything to you." (More hostility)

This last response brings up a point that we sometimes forget. Hostility is contagious; if you aren't wary, it can infect even you. However natural under the circumstances a sharp retort might feel, it could ruin your interview—perhaps the outcome your patient was trying to provoke all along. It could help you maintain your composure if you remember that you have known your patient too short a time to have provoked any personal animosity. Any verbal attack must therefore be the product of your patient's own problems.

If you are talking to a voluntary patient who demands to leave, it is possible that you will never complete the interview. But if your patient is being held involuntarily on a closed hospital ward, time will be on your side.

A 20-year-old man was admitted against his will. In the following dialogue, notice how the interviewer didn't argue, but instead agreed with the patient's every statement, giving each request a twist that required the patient's cooperation:

PATIENT: Look, I don't want to talk to you or any other shrink. Just get me the hell out of here!

INTERVIEWER: That's what I'm trying to do. My job is to help you get out of here. But the law says that I can't let you go until I know it's safe. And I—

PATIENT: Don't give me any of that crap. I want out of here now!

INTERVIEWER: *(Gets up to leave.)* I'll be glad to start working on it as soon as I get the information I need from you.

PATIENT: You mean I've got to stay here all night?

INTERVIEWER: *(Moves toward the door.)* Well, it could be several days.

PATIENT: Wait a minute! You can't just leave me here!

INTERVIEWER: I'll be glad to come back when you're ready to talk.

PATIENT: I'm going to sue you for every nickel you've got!

INTERVIEWER: We'll help you get legal representation tomorrow. But it would be quicker if you'd just decide to cooperate.

This interviewer left the room but returned 20 minutes later at the request of the patient, who subsequently did cooperate fully—and was released a few hours later. The confrontation was defused when the interviewer adopted an attitude of being on the same side as the patient, who could only get what he wanted by changing his behavior.

Defusing hostility can be a supreme test of any interviewer's professionalism. To pass it, you must continually monitor your own feelings and respond in ways that address your patient's emotional needs, not your own.

POTENTIAL VIOLENCE

Patients are only infrequently hostile to the point of violence. Although it's uncommon that a mental health worker is severely injured by a patient, many of us have been shaken up or struck at least once during our careers. At best, this is an unsettling experience—one that we must keep alert to prevent.

Unfortunately, predicting who will become violent is pretty hard. Although the vast majority of seriously mentally ill patients present no danger to others whatsoever, they do account for about 5% of homicides in the United States. In addition to psychoses due to schizophrenia and mood disorders, you could encounter violence in those with cognitive disorders, personality disorders (especially antisocial personality disorder), and acute substance intoxication. You should be especially vigilant when you are interviewing either a male or a female who has any of these diagnoses.

Regardless of diagnosis, an actuarial approach uses the presence or absence of several factors to help predict who will become violent. These factors include relative youth, previous history of violence, a history of being physically abused in childhood, and command hallucinations that order the person to commit violent acts (other types of hallucinations do not predict violence). When any of these factors obtains for a given patient, I tend to be extra vigilant.

During any interview, keep in mind several safety principles. They apply to any clinician but are especially relevant for female interviewers, whom some patients will regard as vulnerable targets. Remember that no one cares as much about your safety as you do. Here are some of the preventive measures you should adopt:

- Review any documentation before you interview your new patient. Be especially wary of someone who has a history of past violence or who seems to have a condition suggesting poor impulse control. Again, psychosis, current intoxication, and antisocial behavior are obvious candidates.

- Ideally, an interview room in a mental health emergency facility will have two doors, both of which open outward. Even if this is not the case, arrange the seating in any room you use so that the patient is never between you and your potential escape route, as I have noted in Chapter 1.

- When you are meeting a new patient for the first time, try to have a security guard available, especially if it is late at night and there are few other people around.

- Many clinics have panic buttons installed under the desks in their offices. If your setting is one of those, be sure to familiarize yourself with its workings and the expected response.

- In doubtful circumstances, leaving the door to the interview room open will also provide you a sense of security and give the patient an added reason for restraint.

- Watch carefully for these signs of heightened tension: clenched fists, loud or quavering voice, angry words, narrowed gaze, or sudden bursts of activity.

- If your patient becomes agitated or otherwise intimidating, remain calm. "Please, just take your seat," you might say quietly. Although some situations can only be met with a show of force, evidence of your own quiet competence may keep the lid on a cauldron threatening to boil over.

You must be prepared to cope with potential harm to person or property. Some people get through life by bullying others; often their threats succeed without their ever having to follow through on them, but it is hard to know in advance just who will follow through with actual bodily harm, or in what circumstances. It is therefore vital to have a three-part plan:

1. With the principles listed just above and the strength of a backup force, ensure your own safety and that of those around you.
2. Maintain your composure as you inform the patient about the consequences of further threats or actual acting-out behavior.
3. Be fully prepared to follow through with the limits you've set, should the need arise.

Suppose that despite your best efforts at forming rapport, your patient displays evidence of unremitting hostility. Then you may have to break off the interview, but try to do it in such a way that you preserve some basis for a future relationship. You might say something along these lines:

> "I'm sorry. I'd really like to work with you, but right now you seem to be pretty upset. Perhaps we can get together again later."

Then leave the room quickly and notify the security staff and colleagues. Remember that it is nobody's job to face single-handedly a hostile, possibly violent patient. "Security in numbers" is trite but true, and it is always your responsibility as a mental health clinician to promote safety—your patients', your co-workers', and your own.

CONFUSION

Patients with confusion* resulting from dementia or delirium present an unusually vexing challenge to the interviewer. They may think and speak slowly, mix up the chronology of events, forget important facts, and have difficulty following your instructions. Frustration with their own poor performance sometimes precipitates hostility. Because the data you obtain from them are unreliable and sparse, it is hard to make a valid diagnosis. Sometimes you will conclude your interview with little to show for your efforts.

The best solution to this frustrating experience is prevention. Before the interview, obtain all the information you can from collateral sources (such as relatives, physicians, other mental health workers, and previous hospital records). According to a recent study, for some disorders such as a long-standing psychosis, medical records may provide the vast bulk of the information you need. Then you can concentrate on your thorough evaluation of the patient's mental status.

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*Confusion isn't a proper medical term, but it is convenient label for people whose thinking appears to be clouded or who describe themselves as being, well, confused.

Even without collateral information, you can take several steps to facilitate your interview with a patient who is confused:

Introduce yourself slowly and distinctly. Before you begin your questions, make sure the patient understands who you are and why you are there.

Try not to rush. You're better off with a few reliable facts than a jumble of inaccuracies.

Use short sentences. Long speeches only compound the confusion.

Choose your words carefully. Jargon and slang may be especially treacherous for the confused patient.

Avoid shorthand phrases. For instance, a confused patient may take your question "Have you been hearing voices?" in its most literal sense.

Ask for repetition. If your patient can repeat the question, it was probably understood.

Ask about the events of a single day. If you aren't having much success with your usual questions, request an account of activities that day, or a typical day's schedule.

You may want to conduct your interview with a knowledgeable informant present. Especially for a patient with moderate dementia, it can increase the reliability of your information and provide support for the patient. Ask permission first.

Don't move too quickly to the formal MSE; some patients with mild cognitive symptoms may notice the jump and take offense.

Keep smiling. At a time when you lack information, you don't want the appearance of irritation to rob you of rapport.

OLDER PATIENTS

Being old does not by itself constitute a disability. Too often, interviewers forget this and assume that patients who are older are also confused, deaf, or feeble. Although you should always try to show appropriate concern, older patients justifiably resent being patronized, physically moved around, or shouted at. Don't let their advanced age deter you from asking questions about activities usually associated with youth. These people are old, not extinct. Many of them still misuse drugs or alcohol, enjoy sex, and even worry about caring for their own parents.

However, there are a number of special considerations to keep in mind when you interview older patients:

• You will probably need more interview time just to get through the sheer volume of material. During a lifetime that spans many decades, the average older patient has accumulated more experiences, both good and bad, than has someone younger. You'll especially need to allow additional time for your older patient's personal and social histories. And because the mental health problems of senior citizens are more likely to be complicated by medical disorders, you'll also need to spend extra time obtaining general health information.

• A stylistic change seems to take place somewhere during the seventh or eighth decade of life: Personality traits become accentuated. In addition, older patients tend to reminisce a lot; perhaps they feel better when they review earlier periods of their lives. Young interviewers should try to accommodate themselves to this slower pace. Speak distinctly, allow more response time, and suggest additional interview sessions if you need them to finish gathering data.

• Older patients have some unique problems that young interviewers may have difficulty relating to. Trying to fill many leisure hours, for example, is a problem with which many young clinicians have had no personal experience; the stress of a low income that carries no promise of future augmentation may be another. Even such ordinary activities as meal preparation and arranging for transportation can burden someone who has become isolated or withdrawn.

• Watch out for instances of elder abuse. This problem, which can include neglect, exploitation, and rights violations, as well as physical and psychological abuse, probably affects more than a million Americans over the age of 65 each year. It is especially likely to occur when an older person has recently become more dependent on a caregiver (who is often the one who administers the abuse). You can screen for instances of elder abuse by asking the following questions:

"Are you afraid of anyone at home?"

"Has anyone at home ever harmed you?"

"Has anyone made you do things you didn't want to do?"

Abuse should be reported to the appropriate adult protective service for your state or jurisdiction. In some states, failure of health care practitioners to report the physical abuse of older patients is a misdemeanor punishable by a fine or jail term.

• Older patients have suffered a variety of losses, which multiply with the passing years. These include loss of health, job, income, status, friends, and family members. Children have moved away; homes of many years have been sold when the owners move to retirement communities.

Perhaps there is no telephone and they don't use the Internet, producing loss of contact with others. Each of these losses demands special sensitivity. This means not only being sympathetic, but also keeping alert to the possibility of denial. Some patients will have difficulty admitting, even to themselves, the waning of their capabilities and prospects. The result may be overgeneralization or vagueness that you must counter with careful requests for more complete information. Here is an example:

INTERVIEWER: How often do you see members of your family?

PATIENT: Oh, pretty often.

INTERVIEWER: For example, when did you last see your son? I understand he lives just across town.

PATIENT: Well, it's been about 6 months, actually.

YOUNGER PATIENTS

Interviewing young people is a pretty big subject (I've written an entire book about it). Because it's often a pediatric mental health specialist who will evaluate a younger child, I won't try to cover interviews that occur on the playroom floor or through a forest of finger puppets. But almost any mental health practitioner might evaluate teens and early adolescents, for whom special issues arise. Most of my comments here just reemphasize some of what I've already said.

First, whereas most adults and a few older adolescents will be seen because they think it is a good idea, children and the majority of adolescents rarely present themselves voluntarily for evaluation. And because it's almost always someone else's idea, you must persuade them that cooperation is a good idea. You must therefore place even more than your usual emphasis on establishing great rapport. In this instance, small talk at the beginning might help your young patient ease into a relationship with you.

Many teenagers will be able to state the reason behind the appointment, so you'll want to speak with them first. Younger children—the exact age range is a bit fluid, depending on the individual child, the family, and the nature of the presenting problem—won't know why they are there, so you'll probably speak first with a parent. For all, it's a good idea to have at least one joint interview; it serves as an opportunity to watch a child interact with at least one parent, preferably both. (During a joint interview, be careful to protect the child from potentially harmful information, such as a parental love affair or an impending job loss.)

A couple of issues in particular could cause a young person to skirt the truth. These include intensely personal questions about drugs or sex,

and the fear that confidences will be breached. To encourage candor, children often need more of an introduction to interview and therapeutic situations than do adults. I might say something like this:

> "Now I need to ask you questions about [sex, drugs]. Sometimes, those subjects cause [kids, young people] to feel so uncomfortable that they just can't talk about them. If you feel you can't tell me the truth, just say that you'd rather move on to something else. OK?"

Most of the time, your patient will steam right ahead with the answers, but when one demurs, you'll have a clearly marked area to which you can return later.

As to confidentiality, deal with that right from the top. I start with something like this:

> "We're here to talk about you and any problems you are having. I'm here for you, and that means that what we say stays in the room. Now there's only a couple of times that I could ever tell something you don't want shared. That's if I think that you are in danger, or if I think that someone else will be. Otherwise, I'm not going to blab to your folks. But in any case, if I ever had to say anything, I'd always warn you in advance."

Most kids will readily accept these statements at face value, as they should. If ever an issue does come to light that you think should be shared, give fair warning and pose a choice:

> "Do you want to tell your folks about this, or should I?"

OTHER ISSUES AND BEHAVIORS

A variety of situations, attitudes, and behaviors can affect the success of your initial interview. Although you probably won't often encounter these characteristics, the response you make can modulate the effect of those that do occur. My overall approach is to regard any issue or behavior that threatens to come between me and the patient as something we should face together. In effect, I frame each situation so as to place the problem on one side, with the patient and me on the other side, working as a team.

Patient Demands

Whether due to narcissism or some other issue—anxiety about loss of status, anger at a spouse or boss—some patients feel they deserve special

treatment. This can take the form of demanding a different hospital room, the privilege to smoke, the right to take notes on (or to record) the interview, or a special appointment time. Because such demands tend to go against the grain, clinicians may feel the urge to push back. I would try to evaluate each situation individually and, as long as it seemed unlikely to usher in a spiraling round of entitlements, make a reasonable accommodation to increase the patient's level of comfort.

> Rodney brought an audio recorder to his initial interview, so he could include excerpts in a biography he was writing. His clinician explained that he did not record interviews, because it could lead to discomfort and possibly loss of information. Rodney put away the recorder, and the interview unfolded normally.
>
> Elaine asked if she could take notes during her initial interview. She said that one of her concerns was that she couldn't remember things as well as she used to; she was afraid that she would later forget some vital concept they had discussed. Her clinician said it would be OK, as long as it didn't interfere with their discussion. By the end of the hour, she had accumulated only a few lines of notes, and her clinician had a good grasp of her emotional issues.

You would apply a similar rational approach to patients demanding VIP treatment on account of wealth, social prominence, or positions of influence or power. Whereas you might acknowledge their special status, you should also emphasize that the opinion they will get from you will be every bit as honest and thoughtful as for any "regular" patient.

Blindness/Major Visual Impairment

Patients with blindness or marked visual impairment can communicate their thoughts, feelings, and experiences just as well as people who can see normally. What they can't do is read the body language all people normally use to help convey concern and requests. With blind patients, you will have to use your tone of voice to indicate that you care, and take extra care with the words you use to say what you want them to do. If you get up, rummage in a drawer, or open a folder, describe your movements. This will help answer questions before they are asked and tell the patient that you are a considerate interviewer who is sensitive to special needs.

Deafness/Major Hearing Impairment

Most patients with deafness or seriously impaired hearing will communicate quite well if you speak distinctly and slowly, while looking right at them to facilitate lip reading. Take care not to hide your mouth behind

your hand or a piece of paper. Of course, you wouldn't ordinarily eat or drink anything during any interview, but here is one more reason not to. In addition, don't shout: Most patients with a significant hearing impairment use hearing aids, and loud noises only distort the sound. Whether or not deaf patients have any residual hearing at all, it is vital not to talk down to them; they may be deaf, but they are not children.

Also keep in mind that many of these people bridle at the medical model of deafness, which implies that they suffer from pathology. These people adhere with pride to the cultural definition of deafness—that is, a community bringing people together through a common physical characteristic and a common language (in the United States and Canada, it's American Sign Language, or ASL). You should ascertain which point of view your patient holds; many deaf individuals vigorously deny that they have a disability at all, and may bitterly resent any implication to the contrary. You could ask for information this way:

> "I understand that many people regard impaired hearing as a cultural issue. Is this something you can tell me about?"

A Background Different from Yours

We are all united by our humanity, but countless features can set human beings apart. Although our training and interests as mental health professionals help us value the variety of life's conditions, we must constantly remain alert for modes of living other than our own.

Aside from obvious features such as age, gender, ethnicity, and language, the search for defining attributes can also apply to a wide variety of other factors. Was your patient reared in a country or an urban setting? Is this patient a college graduate or a high school dropout? A vegetarian or meat eater? We're a country of sports buffs, environmentalists, creationists, evolutionists, wine aficionados, teetotalers, and political junkies. Each of these characteristics, plus countless others, adds to the diversity of life that conscientious clinicians will acknowledge and celebrate.

Some patients will reject you for your own views. I can recall feeling upset when a family of patients I liked told me they were decamping to a clinician whose religious views were more like their own. Only a minority will take steps that drastic, but there will be others who may not fully invest you with their trust—until you earn it—because you are different in some way.

To bridge the cultural divide, perhaps you can exploit your patient's history. For example, in the current era of voluntary military service, most Americans under the age of 60 have had little personal experience with war. A patient's military history serves as a gift to a clinician, who can derive much information about that individual's approach to the world by

asking for details about wartime experiences as a way both to gain information and to solidify rapport.

In fact, the general approach of asking a patient to teach you about any issue involving custom, ethnicity, language, ritual, and more has much to recommend it. It shows your interest in the patient, who will also benefit from a sense of enhanced competence and worth. For patients who were not born in the country where you practice, you might find out how recently they immigrated and what they have experienced, both positive and negative. You might feel some reluctance to delve directly into issues concerning sexual preference, but you can express interest in hearing more information from a patient who spontaneously raises the matter. Other opportunities are afforded by the innumerable varieties of human experience, only a few of which have I mentioned above.

Using an Interpreter

Surveys indicate that nearly one-fifth of U.S. residents speak a language other than English; of these, nearly half aren't fluent in English. This situation is also common in Canada (which is a bilingual nation to begin with). This creates a challenge for most of us who are native speakers of English: To understand patients who do not speak our language, and to help them appreciate their need for treatment, we must communicate through a third person.

For reasons of convenience and cost, it's tempting to rely on an accompanying friend or family member, but that can create problems. Amateur interpreters make more errors than trained professionals do, and embarrassment over delicate matters can result in information that someone close to the patient incompletely transmits, or perhaps withholds completely. Patients themselves may hesitate to reveal sensitive material to relatives or to burden children with issues that are beyond their years of maturity. All in all, ad hoc interpreting yields poorer-quality information and lower patient satisfaction.

Professional interpreters who understand medical/psychological problems are more likely to satisfy. Because they often come from the same culture as the patient, they may have special insight into the pressures the patient faces. If you have a choice, the qualities of warmth and authenticity are more valuable in an interpreter than is a background in science or health care. (An Internet search can help you locate interpreter services in your area.) Even with professionals, take a moment at the beginning to emphasize the importance of complete confidentiality for the material revealed during the session.

Be sure to speak to and maintain eye contact with the patient. For example, you wouldn't look at the interpreter and say, "Ask her if she . . . " Rather, direct your question to the patient, and then let the translator

speak. Some authors recommend sitting in a triangle, so each participant can see the others, but at least one experienced clinician recommends that the interpreter sit beside and slightly behind the patient. This puts the focus of the encounter on the patient–clinician communication and tends to discourage extended dialogues between patient and interpreter. Because humor and metaphors often don't translate well, it's better to avoid them.

If no professional is available, you'll have to make due with available resources. After your caution about confidentiality, ask your ad hoc interpreter not to *explain* your meaning—but rather to repeat what you have said as exactly as possible, right down to the same feeling tone. Of course, it's even more important than ever to use questions that are brief, clear, and open-ended.

Some patients may resist revealing sensitive information to an interpreter. They may not want someone of the same culture to know about, for example, an instance of rape or spousal abuse. Patients with at least some proficiency in your own language may ask the interpreter to leave the room when such material arises. I'd comply with any such request, if I felt that with our limited ability to communicate, I could at least understand the gist of the story. But the reverse situation sometimes occurs, in which you might want to use an interpreter even when the patient has some capacity to understand you. This is because some patients find it hard to explain trauma and other complicated issues in other than their native language.

Crying

Beginners sometimes worry that they'll have trouble coping if a patient cries. To be sure, tears can slow things down for a while, but in the long run they may even facilitate the flow of information about emotions. A quick touch on the arm (one of the few instances of physical contact other than a handshake I'd suggest between patient and clinician) lets the patient know of your concern. Offering a fresh facial tissue serves the same purpose. A few moments of silence may be enough to allow the patient to regain composure with dignity. If the patient cries too much to perceive your concern, be sure to voice it:

> "I can see that this upsets you. Would you like to have a couple of minutes to collect yourself?"

Humor

Jokes can go a long way toward reducing tension, but patients will sometimes cloak their concerns in humor so that a clinician won't give it serious (and therefore potentially threatening) consideration. In any case,

listen carefully when your patient treats sensitive material with a light touch: You may find more cause for concern than is first apparent. And of course, always be extremely chary of uttering witticisms of your own. The initial interview especially, when you don't know one another well, is no time to give your new patient the false impression that you are a jokester who cannot be trusted to take sensitive issues seriously.

Excessive Talking or Rambling

Some patients can be remarkably circumstantial. Left to their own devices, they will tell you far more than you want to know. Sometimes, especially if your patient isn't usually overtalkative, this can be an attempt to avoid confronting unacceptable feelings or revealing sensitive material; much of the time, however, it's just habit. Although circumstantial speech is not usually pathological, it sweeps up way too much chaff for the amount of wheat it provides. Rapport may also suffer when you endure talking that has no purpose, so you should probably intervene if your patient rambles. To attempt a graceful intervention, try to let it take off from something your patient has said. For example, in response to a question about drug usage, this patient spent several minutes discussing the drinking habits of a cousin:

> PATIENT: . . . So I don't think I've ever seen her after 6 P.M. when she wasn't in the bag. Another thing—
>
> INTERVIEWER: *(Interrupting)* But what about *your* drinking?

The clinician had to intervene and restate the desired responses several times before this patient could finally stick to the point.

Even if it isn't their intent, patients who are overtalkative seem to dominate an interview. (Those with mania are notorious in this respect.) You may be able to handle irrelevant comments by only smiling an acknowledgment as you continue with your line of questioning. A more explicit gesture, such as a finger to your lips, may encourage even a boisterously manic patient to talk less. Sometimes you may have to set firm limits, perhaps in the form of a direct confrontation:

> "You have a lot to say that is very interesting. But our time is short, and we still have a lot of work to do. Let's try hard to stick to the subject."
>
> "These details are remarkable, but our first job should be to understand the broad outline."

Suppose the patient harps on one theme, even when you try to change the subject. In this case, you'll need to reevaluate the importance

of this theme to the patient. Confrontation is the most direct method, but it should be phrased diplomatically:

> "It seems to me that the subject of sex preoccupies you. Am I right?"
>
> "We seem to be stuck on the issue of your son's accident. What else about it is important to you?"

For a patient who is extremely garrulous, you may be forced to ask only "yes–no" questions and to resist vigorously any attempt at amplification.

Somatic Concerns

Some patients, even those who do not have a somatic symptom disorder, firmly believe that their symptoms are physical in nature. Despite what physicians have told them, they cling to the idea that their problems can be solved by medications or surgery. There is little value in explaining the probable emotional origin of these complaints: Even after repeated failures, such a patient may continue to search for medicines and operations that will produce relief. Without arguing—one of your goals, remember, is to become the patient's ally—you can point out that physical approaches haven't helped (not enough, at any rate), and that talking about the patient's feelings may relieve some of the anxiety that inevitably accompanies illness. Also, you'll want to work with the patient's medical care provider to ensure that neither physical nor emotional/behavioral issues are overlooked.

Psychosis

In emergency rooms and admitting wards of hospitals, you will sometimes encounter patients with such severe psychosis that they cannot communicate well. Their thinking is tangential or otherwise disordered, and the connections they make between ideas are so illogical that you cannot make much sense of them. You should certainly ask such patients to try to explain their thinking, but the answers may be of interest more for the psychopathology they show than for any historical information they contain. For history that is accurate and relevant, rely on informants or a chart from a previous admission. You can also interview the patients again later, after the psychosis has abated.

Of course, it is important not to buy into such a patient's false beliefs; among other issues, you always want to avoid even the appearance of deceit. When talking with someone who is extremely psychotic, you can focus on behaviors and feelings without agreeing with the patient's suspicions or convictions:

"I can understand how frightening it would be to feel you were being followed. Can you tell me what went through your mind at the time?"

You can also offer reassurance that you believe the patient is being truthful in reporting experiences just as perceived:

"I know you've done your best to tell me exactly what happened. I wonder if there is any other possible interpretation as to the cause."

Some patients, though not psychotic, may have antisocial personality disorder or another personality disorder that interferes with insight; others may be in denial about heavy substance use. Patients without insight may feel no compelling reason to be interviewed. Unless you have some leverage such as a legal mandate or family pressure, you probably won't obtain much in the way of useful information from them. Here is another instance where collateral information may be the only reliable information you can expect.

Muteness

Like deafness, blindness, and other physical attributes, muteness can exist to varying degrees and can have a number of possible causes.

Neurological. A number of neurological problems can cause patients to be mute. Be sure that the patient is fully conscious and alert.

Depression. A patient with severe depression may not be completely mute, but just showing a long latency of response.

Conversion. A patient with mutism as a conversion symptom may be able (willing) to produce a grunt or throat-clearing sound. With patience, coaxing, and praise for progress, you might eventually parlay these sounds into syllables, words, phrases, and sentences.

Psychosis. Someone with severe psychosis may heed voices that threaten reprisals for talking with real people. Head nods and shakes in answer to your "yes–no" questions could help you make this diagnosis. Given pencil and paper, this same patient might be willing to answer your questions in writing.

Gain. Could this patient have a practical reason to appear mute, either completely or partially? Motives such as avoiding punishment and achieving financial gain (insurance, workers' compensation) are the most obvious. If your patient has been overheard speaking normally with other patients or staff, this would tip you off that the muteness is voluntary—I hesitate to use the word *malingering*, because it is pejorative and hard to

prove. To assess muteness, ask any friends or relatives present to leave before you continue your interview. In private, patients sometimes reveal secrets that they could never bear to share with their families. You might coax some people to talk by pointing out:

> "I can get information about you from records, previous caregivers, or from friends or relatives. But I thought you might like me to hear your version."

A relative paucity of speech that is less than total muteness may indicate fear, shame, confusion, lack of understanding, or perhaps a reluctance to contradict an authority figure (that's you). I'd probably try this approach:

> "You seem pretty quiet in a situation where most people have a whole lot to say. I wonder if you can tell me why?"

A somewhat related difficulty is a patient who speaks extremely slowly. Often this is due to depression, in which case you have to strike a balance: Allow enough time to formulate an answer, but don't let the patient twist in the wind with a sense of helpless embarrassment. In such a case, I might ask whether the patient would prefer that I ask some "yes–no" questions. Otherwise, prepare to make a long afternoon of it.

Rarely, you may encounter a patient who sits not only speechless but with a fixed facial expression—possibly one of perplexity. Later, there may be amnesia for the incident. This behavior would put me in mind of two main possibilities: some sort of seizure disorder, such as temporal lobe epilepsy, or a dissociative state. Such patients have probably had other episodes of the behavior, but these may not be accessible through an interview. Try asking:

> "Do you sometimes become absorbed in your own thoughts or daydreams? If you do, can you tell me about it?"

Any such episodes require thorough investigation, perhaps with a neurological consultation. And certainly you should seek confirmation from informants.

Seductive Behavior and Other Inappropriate Conduct

Seductive behavior is less likely to be a problem during the initial interview than during subsequent therapy sessions. However, the potential for seduction is always there, especially when the interviewer is male and the patient is female. (Studies have shown that the vast majority of health care

workers who become involved with their patients are male, though female clinicians are by no means immune.)

If you find that seductive behavior is being directed toward you, ask yourself the usual question: Why is this patient behaving this way? Is it a need to feel attractive? To be loved? Over the years, has aggressive sexual behavior been reinforced with material or emotional rewards? The answers could be buried beneath memories too remote to uncover in a year, let alone in a single interview. Sometimes it's a matter of personality disorder, which can challenge even experienced interviewers.

Seductive behavior may be as subtle as a sideways glance, as suggestive as provocative clothing, or as direct as a request to be held or kissed. Regardless of its form, the meaning of seductive behavior is always the same: danger for the interviewer and danger for the patient. This is because the overt message of seductive behavior ("Embrace me") is often quite different from what the patient really feels ("Help me; protect me"). If a health care professional responds to the literal request for physical contact, the patient may ultimately feel outraged and retaliate accordingly. At best, the relationship and therapy will both be compromised.

The best preventive approach to seductive behavior is to maintain appropriate distance at all times. Address each patient by title and last name, and expect your patients to do the same for you. You can also discourage excessive familiarity if you stick to business and avoid discussing matters personal to you. If you are a male who does physical exams as a part of your job, be sure that a female attendant is always in the room when you are examining a female patient of any age. If you are a female examining a male, have a male attendant with you.

Other inappropriate behaviors may occasionally intrude—a patient who asks to use the telephone, opens books from your shelf, sits in your chair, or brings in lunch. Often the patient's evident diagnosis (I know, that's what you're trying to figure out) and the nature of the infraction will determine your response. For example, I'd try to redirect a patient with mania, repeatedly if needed—perhaps even by using a gentle hand on the shoulder. To someone you already believe may have a personality disorder, I would probably request (perhaps a little sharply), "Please don't do that." In most cases, you would strive to be directive; early in your fact-finding phase with the patient is not a good time to be making interpretations.

Intellectual Disability

Even without formal testing, you can often pick out the patient who is operating on the lower fringes of what is often called general intelligence. Research has shown that open-ended questions can lead such patients to errors in what they report, whereas many will show a bias toward

answering a "yes–no" questions in the affirmative. It is often better to phrase your questions in a multiple-choice sort of way ("Was the voice you heard that of a stranger, or someone you know?"). Even then, it's more important than ever to check the facts with someone who knows the patient well. As you might expect, higher-functioning people with intellectual disability are more reliable interviewees.

Patients with intellectual disability (or what used to be called mental retardation) can often communicate better about events than about feelings. They may interpret speech literally, so (without talking down as to a child) you'll want to speak clearly and avoid using metaphor. It's best to focus on the present: Such patients may have relative difficulty talking about the past or future plans. When their emotions do come to the fore, you may also need to cut them some slack; for a lifetime, these individuals have watched siblings, schoolmates, and nearly everyone else they know enjoy more autonomy than they themselves can lay claim to. Small wonder if they have feelings of resentment that lie not too far beneath the surface—feelings that can pop out in unexpected ways. For example, a woman with intellectual disability who refused to attend her younger sister's wedding was painfully aware that she herself might never enjoy a significant romantic relationship.

Persons with intellectual disability may also copy gestures they have witnessed in others and bring them out at inopportune times—an attempted "high-five" at a moment of general sorrow, for example. One young man of my acquaintance attended a game played by his favorite baseball team, though in the opposing team's stadium. Becoming incensed when fans cheered wildly as his team fell behind, he stood and yelled at those around him, "Hey! What's the matter with you?"

Still another risk is that people with intellectual disability may report as fact that which they themselves cannot verify. For example, a patient was thought by a clinician to be psychotic when he reported that an angel had touched him on the head and blessed him during one long winter night. He clung persistently to that belief; only with prolonged effort was it finally revealed that his mischievous roommate had originated the story. "Well, I didn't actually see it happen; that was Jeremy [the roommate] who told me," he eventually admitted. In the same vein, not all self-injury is evidence of a suicide attempt; it may be self-punishment, an attempt at controlling others, or an instance of stereotypic movement disorder.

Impending Death

Patients who expect to die soon, either immediately or in the near future, are often angry or depressed; sometimes they may deny what is happening to them. It is sad if friends and relatives begin to shun them; it is a tragedy if their therapists also refuse to talk frankly about death and the

future. Mood disorder in dying patients isn't hard to learn about. A study of terminally ill patients found that the most valid way of ascertaining depression was by asking a single question: "Are you depressed?"

Always invite a patient who is dying to verbalize feelings and reactions to this universal experience. Besides a full range of (often conflicting) emotions, you will also find a full range of everyday emotions, including fear, envy, love, hope, and joy. Such patients may have many regrets; some feel lonely. And each has a lifetime of memories and emotions, which must be sorted out as carefully as if this person were going to live forever.

HOW TO RESPOND WHEN THE PATIENT ASKS . . .

Patients are forever asking questions, which is all to the good. Questions offer rich opportunities to provide reassurance, relieve anxieties, and reinforce sound resolutions. Some questions also offer you a chance to put your foot in it, if you don't think carefully.

- "How do you feel about me?" This question is usually a request to be reassured that you like or accept the patient. You can give it, but try to throw in some information or instruction that might provide more substantive help. Here are two examples:

  "I think you're a very nice person who is having a terrible problem with her marriage. It's going to be very important to get your husband to come in for some sessions."

  "I think it took a lot of courage to sign yourself into the hospital. Now let's work together hard on that drinking problem."

- "Do you think I'm crazy?" The answer to this can be hard or easy, depending upon whether the patient does or does not have psychosis. If there is no psychosis, say so. If there is, try to avoid a direct confrontation (your claim that this is psychosis would probably only be rejected, anyway). Instead, you could respond with a question of your own:

  "Why do you ask that?"

  "Are you afraid of that?"

Or you could give an answer that sidesteps the question:

"I think you are clearly troubled by what has happened to you."

"You are having some unusual experiences, but we can help this."

If pushed to the wall ("Look, do you think I'm psychotic?"), I'll opt for the truth, but with the statement that I realize this may be hard for the patient to accept.

• "What should I do about [any concern the patient has]?" If this question can be answered simply, then do so. However, it may be a request for more help than any clinician can reasonably provide during an initial interview session. In that case, try to define what will be necessary (more information, more time) and when you might be able to provide it.

• "What's wrong with me?" (and you don't know). First of all, try not to feel insecure. No firm diagnosis can be made in about 20% of initial interviews, and even experienced clinicians are sometimes initially baffled. If you think there are some good possibilities that won't frighten or threaten the patient, state them. If you need more data, say so. A good generic response would go something like this:

> "It's clear you're having a serious problem with [patient's chief complaint]. We need to get more information, so that together we can work out the best plan for you."

• "Can you help me?" The response should be some variation on "I hope so, but first we need more information."

• "Why don't people like me?" Sometimes the answer seems clear to you, even on first acquaintance: The patient is self-centered, overbearing, prejudiced, hateful, or harboring a host of other attitudes and behaviors that you find off-putting. That's exactly the time *not* to venture an unvarnished opinion. For one thing, first impressions are often wrong; you may have sampled the behavior on an especially bad day, and you are definitely dealing with someone who is under stress. For another, remember your two main goals of the first interview—to get information and to form a relationship. Rather than answering the question directly, you can instead express sympathy for the unhappiness and offer hope for the future:

> "I can imagine how much it would hurt to feel that way, but I don't know whether it's true or not. Together let's try to find out whether we have a real problem." (Notice how this answer puts you and the patient on the same side of the problem.)

• "Have you ever experienced anything like this yourself?" Most patients are interested in their therapists' personal lives, and sometimes you may feel tempted to share something of yourself with your patient. That temptation may increase after the first few interviews, when you have come to know one another better. Although I am not one of those who believes that a clinician should reveal nothing personal under any circumstances, I do agree that self-revelation can be fraught with difficulty, especially for the beginner. Certainly in an initial interview, you will progress further and feel more comfortable if your own life and personality are not at issue. You can answer any personal question by gently

redefining the purpose of the interview. At the same time, be careful to show that you are not upset that your patient has asked the question:

> "A lot of patients wonder about the people who interview them. It's perfectly normal to be curious. But we should concentrate on getting the information we need to help you with your problem."

- "Don't you agree with me that I'm right?" (and you don't). You'll get this question from patients who are experiencing all sorts of issues—psychosis, substance use, illegal activity, even arguments with a spouse. In a first interview, you'd like to avoid a quarrel, but if you buy into the proffered assertion, you set yourself up for complications later. All you need do in such a circumstance is to agree that your patient is having a problem or is uncomfortable:

> "I can see that this is something that [hurts, bothers, troubles] you a lot. We'll want to delve into it more, later on."

If the patient persists in requiring your agreement, you might try:

> "I doubt that you'd want me to jump in before we've established all the facts. So let's move on and get some more information."

- Occasionally patients will emphasize the degree of their illness by asking, "Would you want someone as sick as I am for [a lawyer, a physician, an accountant]?" Trainees can wrestle with the answer to this question, trying to balance their true feelings against what might be good to tell a patient. The best approach is not to answer it directly, but—as politicians sometimes do when confronted with a question they don't want to answer—to reframe the issue: "If I had this much on my plate, I don't know how I'd manage to deal with someone else's problems."

- And for any other question to which you don't know the best answer, here's a workable response that I use: "I can't tell you that right now, but here's how I plan to find out." I will then sketch out an Internet search, discussion with colleagues, further fact-finding efforts, or whatever other approach seems reasonable.

Once again, the take-home point is the importance of figuring out how to work with, not against, the patient. Usually that's easy, but sometimes it requires generous helpings of ingenuity, flexibility, and patience.

CHAPTER 18

Diagnosis and Recommendations

With all interviews completed, you face the task of evaluating your information. It should be organized in a form that is useful for making recommendations and for communicating with patients and other professionals. These tasks will be our concern in the final chapters of this book.

DIAGNOSIS AND DIFFERENTIAL DIAGNOSIS

In the past, some writers have derided diagnosis as "pigeonholing," claiming that it denies the individuality of each patient. Such views now appear to have receded in favor of the majority opinion, which recognizes diagnosis as the essential foundation for these clinical activities: recommending treatment, predicting the course of illness, advising relatives, and communicating with other mental health professionals. Whether or not this opinion is consistent with your usual way of thinking, current mental health practice—hospital record rooms, third-party payers, and sometimes patients themselves—will often require you to make a diagnosis. Regardless of your professional discipline, it will pay you to learn to make the best diagnosis possible.

The importance of accurate diagnosis can hardly be overstated. At best, an incorrect diagnosis delays effective treatment; at worst, it may usher in treatment that is ineffective or even dangerous. Inaccurate diagnosis also risks giving a prognosis that is either too gloomy or too optimistic for the individual patient. Planning then will suffer—planning about marriage, jobs, childbearing, buying insurance, and the myriad other tasks that mental illness can interfere with.

Once made, diagnostic errors can be difficult to reverse. Diagnosis is passed along from one clinician to another, from one chart to the next;

errors are abetted by patients and their families, who carry them along (sometimes for decades) as family mythology. It may be many years before a clinician with fresh perspective takes the time to review a chronic mental patient's history. Yet you can often avoid all of these difficulties if you take the care to make the right diagnosis in the first place.

Making an accurate diagnosis isn't usually all that difficult. Most patients clearly fulfill criteria for a diagnosis with which the majority of professionals would agree, and most don't meet criteria for other, confounding diagnoses. But about 20% of the time, the situation isn't so obvious. You may have insufficient information to make any diagnosis at all, or your patient may seem to meet criteria for several diagnoses at once. And occasionally the facts you think you've determined at the outset disappear or change in the light of further experience with the patient.

That's why most health care professionals state their impressions in terms of a *differential diagnosis*—a list of the possible diagnoses that should be considered for a given patient. You should include in your differential diagnosis every disorder you consider even remotely possible. This is all the more true if you are in some doubt as to the correct diagnosis. You will have a better chance of ultimately selecting the right diagnosis if your working list is broad and inclusive.

In constructing your differential diagnosis, you'll need to consider two principles. Because at times they conflict, they require some discussion.

1. The first principle is to list the most likely diagnoses first, and the rest in decreasing order of probability. Sometimes we call the most likely one the *best diagnosis*, because it most satisfactorily explains all of the historical data, signs, and symptoms of illness. Ideally, all elements of the history and the MSE should support your best diagnosis. But even if you think there is only a small chance that your best diagnosis is incorrect, you should list other diagnoses to be *ruled out*, or disproved. That list, with your reasoning for the order in which you have placed the various possible diagnoses, constitutes the differential.

2. The second one I call the *safety principle*. This means that there are always some possibilities in the differential list with potential consequences so dire that it's just plain unsafe to ignore them. They are the ones that should be placed at the very top of the differential, to be ruled out first, whether or not you think that they actually caused the symptoms. Usually these safety considerations are the substance-related illnesses and general medical (physical) illnesses that *could* explain the symptoms you've identified. OK, so they certainly aren't always your best diagnosis. But whenever one does turn out to be correct, a patient will suffer if it wasn't considered first.

I resolve the apparent conflict between these two principles by, basically, superimposing principle 2 on principle 1. Consider this example:

> Some time ago, some students and I interviewed Amanda. At age 37, she believed that she and her partner were being set up by the FBI as a lure for "drug warlords and kingpins." She was absolutely sure of her grounds—no other interpretation was possible. She was showing some push of speech and occasionally repeating thoughts and words; her thoughts seemed to jump around, and she was a little hard to follow. She admitted to "puffing a little marijuana, but not much." Her physical health had been good. She'd been feeling "a little depressed," but she hadn't felt suicidal.
>
> We developed a list of diagnoses we thought possible for Amanda and arranged them in descending order of probability, but notice what we put at the very top:
>
> Alcohol-induced psychosis
>
> Paranoid psychosis due to an as yet undetermined physical disorder
>
> Paranoid schizophrenia [this one was our best diagnosis]
>
> Mood disorder [bipolar I or major depressive] with psychotic features
>
> Delusional disorder
>
> None of us had much confidence in those first two diagnoses, but they seemed at least on the fringe of possibility, so we cited the safety principle and stuck them at the top of our differential list—to be ruled out first. In our heart of hearts, we thought she'd probably turn out to have schizophrenia.

I've written a great deal more about the structure of the diagnostic process in my book *Diagnosis Made Easier*, now in its second edition.

CHOOSING TREATMENT

Fortunately, mental health patients and their therapists today can draw upon a variety of effective biological, psychological, and social treatments. Most of these are not specific for any one diagnostic category; rather, they can be applied across a spectrum of diagnoses. Some of the available physical (somatic) and nonphysical treatments are listed in Table 18.1. For most diagnoses, there are one or two treatments that are more effective than others. Current textbooks will spell out which treatments are most likely to help in specific diagnoses.

Let me underscore how important I feel it is to have a well-organized plan for approaching each patient's problems and issues. For one thing,

it will help the patient understand what you think is the problem and how you are going to proceed. For another, it will help you keep these same issues in mind. Furthermore, having a treatment plan that you can refer to from time to time offers you and the patient a set of benchmarks to gauge progress, or, alternatively, to help you recognize when to try a different approach. Following are a number of questions to assist you in formulating a treatment plan:

- First, is any treatment likely to reverse the course of this disorder? Unhappily, the answer is sometimes "no." That may be the case for disorders such as dementia due to Huntington's disease. Although many such patients can be made more comfortable, and the social consequences of their symptoms can be lessened, there is no specific treatment to stay the ultimate outcome of disease. On the other hand, using one of the cholinesterase-inhibiting medications such as donepezil can slow the progression of Alzheimer's dementia—for a time. In antisocial personality disorder, a chronic disorder of character that affects perhaps 1% of young men (and far fewer young women), no treatment has yet proved superior to the passing of time.

- How certain is the diagnosis? Treatment has the greatest chance for success when it is based on clinical studies of reliably diagnosed patients. Your confidence in any treatment program will rise in proportion to the certainty that you have made the correct diagnosis. In general, treatments that are risky, complicated, expensive, or time-intensive should be reserved for well-diagnosed patients who have not responded to simpler measures.

What about the use of experimental treatments? Here's my rule, which you may find useful: It is acceptable to use proven treatments in uncertain diagnoses, and experimental treatments when diagnosis is certain. However, it is rarely acceptable to use unproven treatments when the diagnosis is uncertain. In such a case, you are gambling with two unknowns, and the payoff may be disaster. At the very least, if you ever violate this rule, it should be done with full disclosure to the patient and family.

Diagnosis is important in deciding treatment, but it is by no means the only determining factor. Some patients are so ill that treatment must be started even without a definite diagnosis. Acute psychoses provide the most frequent examples: Even while clinicians argue about bipolar I disorder versus schizophrenia, antipsychotic drugs must be started for the patient's safety and comfort. Some problems may merit intervention, even though no well-defined diagnosis is likely ever to be made. Marital discord is an example.

- How urgent is treatment? For most hospitalized patients, the answer is "urgent enough to begin at once." For outpatients, the need

TABLE 18.1. Outline of Mental Health Treatment Modalities

Psychological

Individual
- Cognitive or cognitive-behavioral
- Insight-oriented
- Analysis
- Short-term

Group
- Disease-oriented (Alcoholics Anonymous, lithium clinics)
- General medication clinics
- Family therapy
- General support groups

Behavioral
- Simple reassurance
- Systematic desensitization with reciprocal inhibition
- Mass practice
- Ward token economies
- Thought stopping

Biological

Medications
Electroconvulsive therapy
Transcranial magnetic stimulation
Vagus nerve stimulation
Light therapy
Psychosurgery

Social interventions

Vocational rehabilitation
Social skills training
Education of family
Placement in a facility for acute, intermediate, or chronic care
Involuntary commitment
Conservatorship

Note. Adapted from *Boarding Time: A Psychiatry Candidate's New Guide to Part II of the ABPN Examination* (4th ed., p. 110) by J. Morrison and R. A. Muñoz, 2009, Washington, DC: American Psychiatric Press. Copyright 2009 by the American Psychiatric Press, Inc. Adapted by permission.

may be less immediate. In general, the urgency for treatment will increase under any of the following three conditions:

1. The symptoms are increasing in number. For example, the patient, who has had anxiety attacks for years, has recently also complained of depression, loss of appetite, and trouble sleeping.
2. The symptoms are getting worse. Let's say that in the last few days, this same patient has begun to have recurrent thoughts of suicide.
3. The symptoms lead to alarming consequences. And just this past week, this same patient has felt unable to work and has now resigned after 13 years with the firm.

The three rules just cited can also help you decide which disorder to treat first, in the event that your patient has multiple concurrent diagnoses.

- How costly is the treatment? Unhappily, even in the 21st century, we must still consider the patient's ability to pay. You wouldn't recommend prolonged psychotherapy for a self-supporting student who has no medical insurance. Someone who is fully covered by a health maintenance organization (HMO) or a private or government insurance program may be able to afford the latest in antidepressant medication, whereas a self-pay patient may request an older, generic drug. It remains to be seen what effect the Affordable Care Act will have on this sort of problem.

You will probably have insurance information in hand even before you meet the patient. HMOs, as well as the VA and other government agencies, set their rates in terms that patients are already familiar with. And if you are a private practitioner, your office will probably have included information about fees and other "housekeeping" matters in an initial packet of information sent to the patient in advance of the first appointment. If not, toward the end of the initial interview is an excellent time to go over this information, so as to forestall unpleasant surprises down the road.

When selecting treatment, you must also assure yourself that the desired effects of the treatment outweigh its unwanted effects. This warning applies especially to prescription medications: Will rapid heartbeat or wakefulness cause your patient to "forget" the evening dose? Can some other side effect result in injury or even death? What about interactions with other medications?

- What are the relative contraindications of the therapy you are considering? These are problems that might make you reluctant to use a treatment, but that do not absolutely prohibit it. Common examples are drug allergy, the possibility of interaction with another medicine, and the use of electroconvulsive therapy for patients with known heart disease. You would

also be reluctant to recommend intensive psychotherapy for patients who have a low capacity for insight or who are unreliable about keeping appointments. In fact, a history of nonadherence to treatment reduces still further the desirability of any treatment that is risky or complicated.

- Have you considered all feasible treatment modalities? Therapists of all professions feel most comfortable recommending those approaches they themselves use. Although this is understandable, it breeds the danger that a patient might not be offered an effective treatment with which a therapist has had little experience. The best prophylaxis against the therapeutic rut is an attitude of flexibility.

> Psychiatrists expert in psychopharmacology must ever be alert to the possibility that family therapy might prove quicker, safer, and more effective than drugs.
>
> Social workers, psychologists, and others who provide psychotherapy should keep in mind the indications for which drug treatment can be effective.

The fact that most mental disorders probably have multiple causes should encourage all clinicians to consider using more than one therapeutic modality for any given patient.

ASSESSING PROGNOSIS

The term *prognosis* has Greek roots meaning "to know in advance," which is, of course, impossible. But scientific progress over the past few decades has greatly improved our ability to predict *likely* outcome for individual patients. We'll discuss this in a few moments, after first defining what it is we are trying to predict.

Areas Defined by the Term *Prognosis*

The term *prognosis* implies a number of meanings:

> *Symptoms*. Will they be relieved partly or completely, if at all?
>
> *Course of illness*. Will it be chronic or episodic? If the latter, will there be one episode or many?
>
> *Response to treatment*. How rapidly will this occur? Will it be complete, moderate, slight, or nil?
>
> *Degree of recovery*. Once the acute episode has been arrested (either by treatment or by the passing of time), will the patient's previous personality be completely restored, or will there be residual deficits?

Time course of illness. How long will recovery take? If the illness is episodic, how long is the patient likely to remain well between episodes?

Social consequences of the illness. What will be the effects on the patient's job performance? Family life? Independence? Will financial support be needed? If so, for how long? Does this illness imply the need for conservatorship or other special legal proceedings? How will it affect the patient's ability to vote, to drive a car, to enter into contracts?

Are other family members at risk for this illness? If it is hereditary, what degree of risk do you predict for first-degree relatives? How should you advise the patient who asks about having children?

Factors Affecting Prognosis

A number of factors help us make accurate predictions. Unfortunately, no one knows how strongly any one factor will influence the outcome in any given case. Because each can be important, I have simply tried to list them all, in no particular order.

- *Principal diagnosis*. Diagnoses with major effects (such as mood disorders, dementia, and schizophrenia) usually have more predictive power than those with less wide-ranging effects (disorders of eating, elimination, sleep, and sex). Personality disorders may be especially important for prognosis if no major diagnosis exists or if none can be made with certainty. If your patient has more than one diagnosis, you must keep them all in mind when discussing the various aspects of prognosis.

- *Availability of treatment for the primary disorder.* If effective treatments exist, are they likely to be used? Geography can be an important factor: Does the patient live close enough to a center where effective treatment is offered? Another factor is the patient's financial condition, as demonstrated by this widely discussed example: Clozapine, a drug effective for schizophrenia, was introduced in the early 1990s at a cost of nearly $10,000 per patient per year (enormous for the era). Many patients could not afford it until heavy pressure was brought to bear on the manufacturer to reduce the cost of laboratory monitoring.

- *Duration and course of illness*. Past behavior predicts future behavior.

  If the patient has had previous episodes of illness (such as a mood disorder), you can predict with some confidence that there will be future episodes.

  Barring correction of a previous misdiagnosis, a patient who has been ill for many years stands scant chance of complete recovery.

• *Previous response to treatment*. As a predictor, previous treatment response is only as good as the previous treatment. If in the past your patient has been treated for mania only with antipsychotics, you can upgrade your prognosis by an order of magnitude once mood stabilizer therapy is begun.

• *Adherence to treatment*. Even highly effective treatment is worthless if the patient refuses to accept it. Be sure to consider both major mental diagnoses and personality disorders, as well as treatment history, in evaluating treatment adherence.

• *Available social supports*. Prognosis varies directly with the number of bridges the patient has left unburned. Consider all of these resources for help: family of origin, spouse/partner, children, friends, support groups, social agencies, physicians, and religious organizations. Besides providing comfort, they can help to ensure that the patient continues in treatment and avoids harmful influences such as substance use.

• *Premorbid personality*. Prognosis is directly related to how well the patient functioned before falling ill. Once patients recover from an acute episode of mental disorder, they tend to resume premorbid levels of functioning. Those who have maintained friendships, worked well at their jobs, and provided adequately for their families will probably do so again. All else being equal, parallel predictions are usually warranted for those who previously functioned at lower levels.

• *Highest recent level of functioning*. If productively engaged in work or school during the past year, your patient will probably regain that status once the current episode of illness has been resolved. Of course, this assumes that a deteriorating or chronically debilitating illness has not supervened. The Global Assessment of Functioning provides a convenient scale for evaluating a given patient's progress. You can find it in my book *DSM-5 Made Easy* or by searching online.

• *Other factors*. Within diagnostic categories, individual factors can often affect the outlook for a particular patient. For example, here are a few features that suggest a relatively good prognosis for a patient with schizophrenia: relatively late onset (30s or later), being married, female gender, education beyond high school, brief duration of untreated symptoms, and good previous response to treatment.

RECOMMENDING FURTHER INVESTIGATION

Further study may be necessary to confirm or rule out specific diagnoses. Resources for this information include the following:

A review of prior hospital and other records

Laboratory tests, including radiographic studies

Formal neuropsychological testing

Interviews with relatives

Further interviews and study of existing records usually cost nothing. They often provide new or corroborative information that can rapidly advance your understanding of your patient. Because testing costs both time and money, its use should be justified by the facts of each individual case. Tests ordered as a part of an admission routine and not in response to a perceived need are only rarely cost-effective.

When laboratory or psychological testing is involved, it should be justified on the basis of these factors:

- *Cost of the test*. The range is enormous, from nothing at all to thousands of dollars.
- *Risk of the test*. Pencil-and-paper psychological tests have essentially no risk; some invasive procedures can imperil health and even life itself.
- *Value of the test*. How strongly confirmatory will the results be? A costly lab procedure that has a good chance of nailing down a difficult diagnosis may well be worth the expense; a routine urinalysis that has no bearing on the diagnosis is far too expensive .
- *Prevalence of the disorder*. Routine testing for rare disorders is not cost-effective. However, this does not mean that you should avoid ordering confirmatory tests for uncommon disorders that seem possible on the basis of history or physical exam.
- *Complexity of the question to be answered*. If the patient's illness is relatively simple and straightforward, you may well be able to omit laboratory testing completely.
- *Will the procedure facilitate treatment?* It is well and good to know what's wrong; it is better to learn how to fix it.

MAKING REFERRALS

You are likely to recommend mental health therapy that is directed specifically at your patient's complaints. You should also keep in mind the range of other treatments and referrals that may be needed, either to help manage the presenting complaints or to deal with social, psychological, and biological problems that are incidental to the main problems.

Many organizations and individuals can help you manage nearly any problem you might encounter. This is fortunate, because no clinician has the training and experience to do it all alone. It is vital that you know the limits of your own capabilities and refer for outside help those aspects of each patient's difficulties that can be better treated by others.

How much outside help will be needed will depend on these factors:

Type of problem. A clinician whose training neglected behavior therapy techniques may need some assistance with a patient who presents with obsessions or phobias.

Severity of the problem. Mild depression may respond to cognitive therapy; severe depression may require the services of a clinician skilled in psychopharmacology.

Strength and extent of support network. To give an obvious example, a homeless patient will require more social services than one who lives with relatives.

Patient's motivation and cooperation. Obviously, a patient's refusal to be hospitalized limits the scope of services that can be brought to bear.

The clinician's training, experience, and available time. I strongly recommend that students try to gain familiarity and experience with as many types of treatment as possible.

Although many of the resources mentioned in this chapter have traditionally been provided or arranged by social workers, all mental health professionals should be aware of the types of services available in the geographic area where they work. Too, clinicians in private practice will often find that they must arrange for their own referrals. Of course, you can use only the services you know about; hence this listing.

Other Therapists

No one can know everything; wise clinicians know their own limitations. If you practice group therapy and your patient needs olanzapine, of course you will refer the patient to a physician for medication. If drug therapy is your strength and you do not provide cognitive-behavioral therapy, it is important to refer your patient for such therapy when it is indicated.

Mental Hospital

Although laypeople often consider hospitalization to be a last resort, in several situations the modern mental hospital is the most sensible recourse:

When patients are dangerous to themselves

When patients are dangerous to others

When patients are unable to care for themselves

When the desired treatment is only available to inpatients

When the patient must be removed from the environment

When intensive evaluation is required for medical or legal purposes

Clinicians tend to be conservative when it comes to protecting their patients' lives. At least regarding suicidal ideas, which are probably the most frequently cited reason for hospitalization, most clinicians would agree that it is better to err on the side of overhospitalization.

Shelters

Shelters are vital resources for patients who do not need to be hospitalized, but who for various reasons cannot live at home. Specialized shelters are operated for the protection of abused children, battered women, runaway adolescents, and homeless men, women, and families.

Legal Assistance

Legal help may be needed for problems that might either cause or grow out of a mental disorder; sometimes the legal problems may be unrelated. If your patient has inadequate resources and needs services as varied as drawing up a will or fighting criminal charges, referral to a legal aid professional may be necessary. If the problem concerns elder abuse or child abuse, refer to adult protective services or child protective services, respectively. Contact information for these agencies can usually be found through an online search or in the county government listings in the telephone books of most major cities.

Support Groups

Many support groups are modeled after the famous Alcoholics Anonymous Twelve Steps. Most groups cost nothing to join, and many are nearly ubiquitous, having chapters throughout the country (and in some cases throughout the world). The name of a group usually describes its function. Although a complete listing of support groups is impractical (their name is legion), here are a representative few:

Adult Children of Alcoholics

Adults Molested as Children United

Al-Anon (for families)

Alateen

Alcoholics Anonymous (AA)

Batterers Anonymous

Gamblers Anonymous

Narcotics Anonymous (NA)

Overeaters Anonymous

Parents Anonymous (for parents who have abused their children)

Parents Without Partners

Recovery Inc. (for those with emotional problems)

Other Resources

Acute substance use treatment. Detoxification services are usually available through referral from county mental health centers.

Medical evaluation. Available at county, state, city, and private hospitals for evaluation of rape, trauma, HIV status, and diseases of any type.

Vocational services. Including evaluation for disability, job training, and unemployment compensation, these services can be accessed through state and county employment offices.

CHAPTER 19

Sharing Your Findings with the Patient

Clinical findings and recommendations become far more useful when they are shared with others. The most important instance of this sharing is with the patient, but it often extends to the family as well.

CONFERRING WITH THE PATIENT

Whether or not you see an outward indication of nervousness, your patient will probably be feeling apprehensive about the results of your findings. This is why you should plan to discuss them just as soon as you can. Many clinicians do this at the end of each initial interview. Complicated problems may require more interviews or time to review materials. Even so, some sort of interim report will be appreciated, even if it is only a few sentences.

What you say will be governed to some extent by the patient's capacity to comprehend; this in turn may be heavily influenced by the disorder itself. But most patients can understand and appreciate the truth, which is what you should always strive to communicate. Early in my career, I'd feel reluctant to tell a patient that my diagnosis was schizophrenia, because it so often carries an ominous prognosis. But after a few such encounters, I discovered that patients tended to accept this diagnosis about as well as any other, and I stopped worrying—as long as I was sure I was right.

If you follow a few simple rules when communicating your findings, your message will stand a better chance of being both heard and accepted.

Summarize the problems. By doing so, you give assurance that you really do understand why the patient has come for help. In the event that you don't understand as completely as you thought, the patient has the opportunity to educate you further.

Give a diagnosis. State your best diagnosis in terms appropriate to the patient's education and sophistication. If you are unsure of the diagnosis, say so—and then lay out your plan for resolving your uncertainty (more tests? a therapeutic trial?).

Keep it simple. Bear in mind what the patient really needs to know, and convey that. This is no time to teach a graduate seminar in diagnostics.

Don't use jargon. The information should be transmitted in plain language. If you use a lot of four-dollar words, you risk obscuring part of your message while the patient tries to decipher the code.

Keep asking for feedback. You'll get better compliance with recommendations and greater patient satisfaction when you assure through questions that the patient understands your explanation of the problems and the proposed approach:

"How do you feel about this?"

"Do you have any questions so far?"

Emphasize the positive. With the many therapeutic approaches mental health professionals have at their disposal, even gravely serious problems such as schizophrenia and bipolar I disorder can be helped.

Show your compassion. Watch for changes in the patient's affect as you provide information. Acknowledge the patient's feelings, and offer sympathy and suggestions as to how things might improve. Remember that everyone needs the feeling of hope.

Discussing Treatment

The treatment plan you arrive at should be structured as a collaborative effort between clinician and patient. Although this approach to treatment planning requires more initial effort, in the long run everyone will benefit. A plan shared with the patient is an important part of the initial interview.

What do patients want from their clinicians? I tend to answer this important question with another question: Exactly what would I want if I were the patient? I would want a sensible plan that linked diagnosis to rational treatment. I would also want a clear explanation of the treatment

process, its possible pitfalls, the alternatives to treatment, and an honest appraisal of its chances for success.

A concrete plan for further investigations, as well as treatment, would help me feel hopeful for the future. Because it would put me back in control, I'd be more enthusiastic about it and less likely to drag my feet about implementation. (I'll say it again: A patient who buys into the plan is more likely to cooperate with it.) I'd also want a clinician who was so keen to ensure my understanding that, if I asked questions, they would be treated not as challenges to authority but as opportunities to engage me in the treatment process. My treatment adherence would be enhanced: I'd probably remember my appointments, try to do assigned exercises, and seldom skip a dose of medicine. My improvement wouldn't be delayed, and I'd avoid treatment failures and dropouts from therapy. If something went awry and treatment didn't work, I'd be far less likely to lay blame on my clinician than if I hadn't signed on to the plan in the first place.

In the negotiated approach to treatment, patient and clinician together formulate the plan. This doesn't mean that the patient gets everything that's wanted, but that the clinician does listen to the patient. You can encourage your patient to "want" or choose the plan that you think would be best, but you must listen and react appropriately if the choice is different from what you recommend. I've sometimes felt, for example, that a teenager chose wrong when rejecting medication for depression. "I want to do it myself" is the typical response. But I've always accepted the decision with the best grace I could muster—and very often, several appointments down the road, the patient volunteers the opinion that "this isn't going as well as I'd hoped, and maybe I should try your pills after all."

When you are drawing up the treatment plan together, here are several points to consider:

- *Discuss the options*. It is human nature to feel more in control when there are choices; therefore, you should run through a complete list of the possible treatment options. One obvious choice that is seldom mentioned is no treatment at all. I often start with this one, because it allows me to discuss in concrete terms what I foresee as the outcome of no (or inadequate) treatment. This serves as a useful benchmark against which to measure the potential drawbacks and benefits of the other choices.

- *Mention the drawbacks*. No treatment is free of them: Medicines have side effects, psychotherapy takes time, group therapy involves other people, and behavior modification requires effort and anxiety. All of them are expensive. Negative aspects of treatment are unpleasant to contemplate, but patients need to know these things so they can make rational choices. Some states have laws that require patients to be told about alternatives to drugs, electroconvulsive therapy, and other somatic treatments.

• *You can favor one option.* Most of the time you will probably convey your opinions directly. But for patients who feel the need to defy authority or who strongly desire a particular form of therapy, you may want to exert your influence more subtly. For example, you can find good news about drug therapy for the patient who needs it:

"You won't have to wait forever to gain control of your symptoms."

You can also find good news for the patient, perhaps one with a personality disorder, who doesn't need drugs:

"You won't have to give up control of your own body."

Neither of these statements is untrue, and each can promote one of the goals of mental health professionals: to encourage patients to accept what will help them.

• *Make sure the patient understands the options.* Most patients will understand, but under stress people can have difficulty focusing their full attention on what they are being told. If you have any doubts that your instructions about treatment were heard, ask the patient to repeat what you have said—"to see if I've been as clear as I should be." Providing a brief written summary of your recommendations is another way to help your patient understand you.

• *Avoid making promises, other than that you will do all in your power to help.* Of course, you cannot see into the future, and on some level patients know this. But patients (and families) are also often so worried about the future that they invest us mental health clinicians with powers we don't possess. Clinicians have gotten themselves into serious difficulties by painting a view of the future that is rosier than the data and the experience of others will support. When you offer hope, it should be in the context of a realistic view of the situation and a rational plan for the future. It should emphasize the importance of the patient's cooperation with all aspects of treatment—including questioning any of your conclusions or directions that might not be understood.

Motivating the Patient

Of course, without implementation, the best treatment plan in the world will accomplish precisely nothing. And far too often, that's the outcome of a mental health consultation. Despite the best efforts of the clinician, a patient may forget to take medication, neglect behavioral exercises, or go ahead and drink or use drugs anyway.

Why do so many patients appear unwilling to improve? Often it can be traced to a lack of hope, perhaps based on long experience with the mental health system. Or disorders of personality or substance use may

motivate people in ways that compete with the therapeutic plan. Although greater knowledge about mental disorder may illuminate the source of the problem, it doesn't necessarily give the individual a sense of control, and studies have shown that education alone doesn't go far toward motivating change. (It may already have been tried, perhaps cloaked—and choked—in exhortation.)

Enter *motivational interviewing* (MI), a client-centered approach first used for patients with substance use disorders. MI attempts to persuade people to adopt new behaviors they need for health care or other reasons. Instead of confrontation, it emphasizes collaboration; for education, it substitutes *evocation*, which means unlocking resources for change that a patient already possesses. MI helps get people off the dime and past ambivalence, to identify their own inner motivation. In controlled studies, MI has been repeatedly demonstrated useful—even in the vast majority of patients with schizophrenia.

MI is based on the principle that it's easier to get people to do something positive than it is to prevent them from doing something negative. It's the "catch more flies with honey than with vinegar" approach. A patient doesn't have to commit to global change, only to some specific behaviors. Although whole manuals have been written about MI, it can be summarized in four basic steps:

1. *Empathize*. Without criticizing, you help the patient express feelings and viewpoints. Note that you don't have to agree with the patient's point of view, just facilitate its expression. Practitioners of MI call this step "Express Empathy."

2. *Help the patient recognize how current behavior is frustrating long-term wishes*. The perception of that discrepancy is what motivates the patient to seek behavioral change. "Develop Discrepancy" is its name.

3. *Don't argue with resistance*. Instead, use it as an opportunity to explore the patient's feelings further. In MI, resistance means that the clinician needs to adopt a different approach. This step is called "Roll with Resistance."

4. *Provide hope by showing you believe the patient can succeed.* Give the patient the confidence that change is possible. "Support Self-Efficacy," this step's called.

Here, somewhat condensed, is a conversation with a young woman who has mild intellectual disability, lives with a roommate, and has a job stocking shelves at a local grocery store. A long-time client, Misty has once again been having difficulties with her budget. The comments in italics highlight the use of the four MI steps.

CLINICIAN: I understand that you've had a letter from your bank.

MISTY: Right, they said I was overdrawn again. And Janice [the resident manager at Seaview, the patient's independent living facility] says I could lose my account.

CLINICIAN: That would be too bad.

MISTY: Yeah, I'm bummed.

CLINICIAN: I can imagine. Anyone would be. What happened to get you overdrawn?

A classic expression of empathy–step 1.

MISTY: I guess I wrote too many checks.

CLINICIAN: What were they for?

MISTY: You know—my cable, bottled water, rent, telephone. That's all.

CLINICIAN: That doesn't seem like a lot.

MISTY: It isn't. I always pay them on time.

CLINICIAN: I know, you've done a wonderful job with those responsibilities. I'm always so proud of you.

With praise for Misty's previous success, the clinician reaffirms their past connections and expresses confidence in her abilities. Step 4–support–shouldn't wait for new actions from the patient.

MISTY: And I bought some stuffed animals. I have a collection.

Misty and her clinician further list income and expenses; the clinician learns that since the holidays, Misty has been working fewer hours, so her paychecks have been reduced.

CLINICIAN: So you have less money right now.

MISTY: Right.

CLINICIAN: What do you think you can do?

MISTY: I could ask my mom for money.

CLINICIAN: And would she help? What happened last time?

MISTY: She said no, I'd have to spend less.

CLINICIAN: How would that work?

MISTY: Well, I have to pay rent.

CLINICIAN: Of course. What about the other items on this list?

They talk about the other bills, and agree that the telephone is essential. The clinician wonders about Misty's bottled water.

MISTY: It's crystal pure.

CLINICIAN: Do others at Seaview have bottled water?

MISTY: No, just me and Arlene [her roommate, whose finances are, if anything, even more straitened than Misty's].

CLINICIAN: And what would happen if you didn't have it?

MISTY: We'd have to drink tap.

CLINICIAN: Like the others.

MISTY: Yeah.

The clinician interprets the ensuing prolonged silence as evidence of significant resistance, and decides to approach it obliquely (step 3).

CLINICIAN: I guess you'd rather not change, right?

MISTY: Right.

CLINICIAN: Bottled water is nice, and you're used to it.

MISTY: Right. We use it for cooking, too.

CLINICIAN: You're used to your cable TV, too.

MISTY: Well, sure. We both like the cooking shows a lot.

CLINICIAN: You're lucky; you both like cooking and the cooking shows.

MISTY: We like to eat.

CLINICIAN: You'd like to keep them both.

MISTY: Yeah, we need them.

It develops that Misty and Arlene subscribe to every premium service their cable TV company provides, including full sports, HBO, and Showtime. The discrepancy between what Misty would like and what she can afford (step 2) is implicit, but perhaps should have been brought out more clearly.

CLINICIAN: You know, I used to have HBO and Showtime, too, but I cancelled one of them. I thought I didn't need both.

MISTY: Mm-hmm.

CLINICIAN: What do you think?

MISTY: I think people who live in a house have money. They can choose if they want.

CLINICIAN: I see, and you feel that you don't have much of a choice, is that it?

MISTY: Right!

Misty has made her point–a perhaps surprisingly insightful one that describes and explains her resistance to having a choice forced upon her. Realizing that Misty recognizes the discrepancy between what she can afford

and what she wants, but needs time to work out what to do, the clinician backs off and says that they can work some more next time on solving the problem. This expression of support leaves Misty with the feeling of being heard and of having some hope for the future. Later in the week, she calls to say that she and Arlene have decided to get by on tap water for a while.

Although MI itself is relatively new, clinicians have negotiated with patients for generations; the technique was advocated by psychiatrist Adolf Meyer over 80 years ago. Clinicians who avoid parentalism and empower their patients in pretreatment decision making often find that they promote greater patient satisfaction. Furthermore, patients who have positive relationships with their clinicians are more likely to be happy with treatment and to find it helpful, even in the case of electroconvulsive therapy. Other research has demonstrated that patients accept treatment and follow through with it better when clinicians express empathy, are willing to explain and share information, and are accessible to patients on their own terms.

Obviously, the benefits of MI will not hold in the face of advanced dementia, blatant psychosis, acute suicide plans, or life-threatening anorexia nervosa. But as the story of Misty and her clinician demonstrates, it can work even in patients with intellectual impairment.

DISCUSSION WITH THE FAMILY

A close-knit family will want to know all that can be done for the patient. Many relatives have had considerable experience in dealing with mental health professionals; for some, this involvement hasn't always been satisfactory. The quality of their experience this time will usually be in direct proportion to the following:

The amount of contact they have with you

The degree to which they feel they have input

How caring you appear to be

The patient's opinion of you and of the treatment plan

You can avoid problems of confidentiality if you meet with the family while the patient is present. Of course, if you need more information than your patient has provided, a portion of your family session may have to take place with the patient absent. If you do meet separately, be sure to tell your patient—who, you can point out, has had plenty of opportunity for confidential sessions. No matter how or where this meeting occurs,

you must carefully withhold the details of any privileged communication with the patient.

If this is your first conference with family members, you might begin by learning what they already know about the disorder. This will help you judge their prior assumptions, and so you could avoid discomfiting them with information that directly contradicts what they may have been told earlier. For example, if a previous therapist has diagnosed schizophrenia and you believe that the diagnosis should be bipolar I disorder, you could emphasize the psychotic symptoms that both clinicians have regarded as key. Mention any diagnostic concerns you might still have, especially if relatives could provide information that might help; whether the patient started drinking before or after becoming depressed is a good example. Early in this meeting is also a great chance to help convey any positive messages your patient has expressed to you, such as a concern for the effects of illness on relatives.

Once you've obtained whatever information you need, you could outline the treatment plan—including its strong and weak points, so as to forestall later recriminations if problems should develop later. Emphasize aspects where relatives and friends might be able to help. For example, changes in behavior or emotional state may be more evident to relatives than to the patient. The emergence of side effects would be one such issue; here, in the case of a patient with a current depressive episode of bipolar I disorder, would be a place for "manic alert" instructions.

Even if you can't provide much effective treatment, as for a patient who is rapidly sliding into dementia, you can discuss resources that may help the family cope. Just about any family trying to cope with a relative's mental illness can benefit from some degree of social support; find out what's needed and what resources they've been using. They may even mention some you didn't previously know about.

In closing, be sure to tell relatives how to get in touch with you, and emphasize that you want all three groups—the patient, relatives, and you—to work together as partners in problem solving.

WHAT IF THE PLAN IS REJECTED?

With the stress of mental illness in the family, it is not uncommon for someone—usually the patient, but sometimes a relative—to object to the treatment plan. If it is a relative or friend, and you and the patient agree about how to proceed, move ahead with the plan. But say something to the relative that shows you have considered the dissenting point of view:

> "I'm glad you told me that you don't want your brother hospitalized. But he and I both feel it is the safest thing to do right now, so I think

we should go ahead with it. I hope you'll visit him. You know him better than just about anybody, so I'll need your eyes and ears to help me judge his progress."

If your patient is the one who balks at treatment, proceed with a series of steps that might resolve your impasse:

1. Try to discover what about the plan is not acceptable, and then offer reassurance. For example, side effects of treatment may be tolerable if the patient can be reassured that they are likely to be short-term.

2. Identify the areas that you do agree about. If it is the need for some treatment, proceed with the next step.

3. Learn what therapeutic measure the patient will accept. If it is something you feel will not be harmful, just not helpful (such as psychotherapy alone for moderately severe depression), you may agree to try it for a specified period. At the end of that time, the patient may agree to proceed with your original recommendation.

4. You may agree to an experimental trial, with the proviso that you will monitor the results carefully and stop or change treatment if the patient feels dissatisfied.

5. Offer to arrange for a second opinion. This may be especially useful if a trusted friend or relative is influencing the patient to reject your recommendation. But keep an open mind: Your consultant may recommend something that is different from what you had in mind.

6. Finally, it is possible that either the patient or the family may reject treatment you consider to be essential. Here's my rule: I may proceed with a course of treatment that I believe is fully warranted against the wishes of either the family or the patient (in the case of a patient who is involuntarily hospitalized). But if both patient and family reject my advice, I will usually feel unable to work effectively with this patient. In such a case, I will try to help the patient find another clinician.

CHAPTER 20

Communicating Your Findings to Others

Somewhere, sometime, a mental health clinician might conceivably do an evaluation and provide a complete course of treatment without saying a word to anyone but the patient. If ever it happened, this rare event would probably take place in the office of an isolated private practitioner. But the demands of insurance carriers, HMOs, and government agencies make it increasingly likely that, regardless of where you work or who your patient may be, you will have to communicate your findings to someone.

THE WRITTEN REPORT

Even the most expert of clinicians collect their data somewhat haphazardly. It is therefore necessary to organize your findings before reporting them. For written and oral reports, the organization of material will be about the same. Written reports are usually the more complete, so I'll discuss them first and in far greater detail. Appendix C provides an example of a complete interview and written report.

Identifying Data

The identifying data provide the reader with a framework upon which to construct a mental image of the patient whose history you are reporting. In the first line or two of the report, you state the basic demographic data, including the patient's name, age, sex, marital status, religion, and any

other item that seems relevant. In the military services, identifying data also include the patient's rank; in a VA hospital, you might note whether the patient has a service-connected disability.

In any case, you should note that the patient either is new to your facility or has been seen there before.

The Chief Complaint

As described in Chapter 2, the chief complaint is the patient's stated reason for coming to treatment. It is often written as a direct quote, but sometimes you'll want to paraphrase or summarize it—especially if it is vague, long-winded, or multifaceted. Occasionally a clinician cites two chief complaints: one from the patient, and another from a (suitably identified) relative, friend, or other informant. This double reporting is especially useful for patients who are uncooperative or are too confused (or too young) to respond appropriately when you request the information.

Informants

Briefly state the names of those from whom you have obtained your information, and estimate the reliability of each. Besides the patient, mention relatives, friends, other health care workers, and old charts—anyone or anything you have used to help round out your picture of the patient.

History of the Present Illness

The history of the present illness is the most important section of the entire report. When you are writing up this history, keep in mind several rules.

- It should be a chronological history. Like all good stories, this one should have a beginning, some development, and an ending. In most cases, it will begin with the onset of the first episode of illness. Some clinicians carefully mark that point with an opening phrase something like this:

> Mr. Turner was well until age 32, when he suffered the first of several episodes of depression.

Note that in this single economical sentence, the reader is alerted to (1) the principal area of clinical interest (mood disorder: depression), (2) the age of onset, (3) the fact that Mr. Turner's problem is not a new one, and (4) the patient's good health during the decade of his adult life prior to the onset of this illness. Once your narrative is underway, it

should proceed more or less chronologically, ending with the reasons that prompted your patient to enter treatment at this time.

For patients who have been repeatedly admitted to one facility for the same condition, you might choose instead an interval note—one that's abbreviated to avoid needless, lengthy repetition from one chart to the next:

> Since age 32 Mr. Turner has had five admissions to this medical center for severe depression, each of which has been successfully treated with electroconvulsive therapy. Following his most recent discharge 2 years ago, he had been living independently and working at his trade of commercial illustrator. Two weeks ago he noted the lethargy and loss of interest in work that usually herald the onset of a depressive episode.

- Support your best diagnosis. This means that the material you feature should reflect the current diagnostic criteria (DSM-5 in North America) for the diagnosis you think most likely. Let's say, for example, that your patient has symptoms of both depression and psychosis. You believe that the most likely diagnosis is melancholia with psychosis (in DSM terms, major depressive episode, severe, with psychotic features and with melancholic features), so the history of the present illness should emphasize the finding that your patient never has psychotic symptoms except during a profound depression. Of course, I don't mean that you should try to hide ambiguities or evidence of competing diagnoses. But your write-up should, insofar as is consistent with the data, form a picture in which history, mental status, and diagnosis are mutually supportive portions of a consistent whole.

- If the story is complicated, try to disentangle it. One way to accomplish this is to leave until later details that don't support your best diagnosis. Perhaps this less relevant information can be included later in the personal and social history. You could also present distinct (though possibly intersecting) themes as separate paragraphs in your history of the present illness. After describing your patient's depressive illness, which was the actual cause of his hospitalization, you might continue as follows:

> In addition to his depression, Mr. Turner has also had a tendency to cross-dress. This began at about the age of 6 . . .

- Edit your material. If you have just sat through an hour-long interview and read an old chart as thick as the U.S. federal budget, you may have learned far more than most readers will need to know. To boil down your material, you can summarize previous treatment in a line or two; enumerate hospitalizations (so many for mania, so many more for depression); and list symptoms of a typical episode. This saves your reader from multiple repetitions of essentially identical information.

> At that time [of his first episode of depression] he first noticed lethargy and lack of interest in his work as a commercial illustrator. Over the next few weeks he became increasingly anorectic, lost 10 pounds, and suffered insomnia that caused him to get up and pace the floor early each morning. This symptom pattern has been repeated during subsequent episodes.

As Platt and McMath (1979) have noted, "The present illness should be an elaboration of these primary data, not a saga of medical care."

- Include significant negatives. When investigating various areas of clinical interest, you asked many questions to rule in or out certain disorders. Some of the negative answers helped you choose the most likely diagnosis on a differential list. Such answers are called *significant* (or *pertinent*) *negatives*; they should be reported in your history of the present illness, along with the important positive answers:

> Although Mr. Leeborg said that he felt severely depressed in the week since he lost his job, he denied insomnia, loss of appetite, and lack of interest in sex.

- Report your findings in plain language. Your readers may include people who are unaccustomed to the sometimes perplexing jargon of the mental health field. Avoid abbreviations other than those commonly used in professional journals. Short sentences and active verbs will demonstrate the clarity of your thinking.

- The patient is a person, not a "case." Many clinicians consider it bad form to refer to patients as "this manic" or "a schizophrenic." Always strive to refer to your patient as "a person with mania" or "a patient with schizophrenia." Such wording helps to preserve the reader's feeling for the humanity of your patient.

Personal and Social History

Childhood through Adult Life

When you present your information, keep things orderly by adhering as closely as you can to chronological sequence. Begin with birth and early childhood, and proceed through education, military experience (if any), sexuality, marriage, work history, legal history, and religion. You can use either a paragraph or outline style; the former will be more convenient if you dictate, the latter if you handwrite or keyboard your information.

In this section, strive to present a reasonably complete picture of your patient's background. Even so, you should generally omit data already covered in the history of the present illness. Edit out the anecdotes and trivial details with which patients invariably illustrate their life stories.

You should, however, include pertinent negatives—such as the absence of childhood sexual abuse in a patient with a possible dissociative disorder, or perfect school attendance in a patient with possible antisocial personality disorder. Also include important past positives, such as previous drug or alcohol misuse, that you might have omitted from the history of the present illness because they no longer affect your patient's life.

Family History

Although it is properly a part of the patient's own life story, family history is traditionally reported in a separate paragraph. Perhaps we do this to emphasize the biological and environmental effects families can have on the developing individual. Include the data you have obtained for physical as well as mental disorders. When reporting the latter, be sure to include not just the diagnosis, but also whatever information you have obtained that would substantiate (or refute) that diagnosis. For example:

> Although Mrs. Garwaith's father had been diagnosed as having schizophrenia, he had twice been treated in hospital and released, apparently recovered and able to resume the demanding occupation of singing waiter.

Later, in the summary, you might conclude that the father's history sounds more like a mood disorder.

If the patient was adopted or if the family history is completely negative, say so and move on.

Medical History

Mention any operations, major medical illnesses, current and recent medications, and hospitalizations for reasons not related to mental health. List any allergies, especially to drugs. If there are none, say so; this information may assume importance, should drug therapy become an issue for your patient. If you have not already done so, mention any habits such as the use of tobacco, marijuana, or alcohol.

Review of Systems

Mention any positive responses to your questioning about past or present physical problems. If somatization (somatic symptom) disorder has been a consideration in the differential diagnosis, list the symptoms you scored positive in that disorder's specialized review of systems (see Appendix B for details).

Mental Status Examination

For many patients, much of the MSE will be normal and can therefore be covered briefly. The order in which you report the various areas is not as important as the fact that you mention each, if only to show that you have considered them all. In describing your patient's mental status, keep in mind which details would be needed to support or refute the diagnoses included in your differential diagnosis. Include not only positive information, but also the important negatives that allow you to place diagnoses higher or lower in your differential listing.

Describe the patient's general appearance and clothing; contrast apparent age with stated age. Be sure to mention all aspects of affect. If type of affect is unremarkable, "about medium" will do as a descriptor, but also mention lability and appropriateness. When you are trying to describe abnormalities, don't use general terms such as "bizarre" or "peculiar," which lack precision and carry none of the flavor of the patient's behavior or appearance. Instead, take the trouble to choose words and phrases that are truly descriptive: Instead of "The patient's clothing was strange," you might say, "The patient was dressed in a tutu and body stocking hand-stitched from old flour sacking."

Remember that written mental health records are legal documents. They can be subpoenaed by attorneys and requested by patients themselves, so make sure that your tone and wording will withstand scrutiny. Avoid jokes, complaints, and any other comments that should be kept private. If you need to express an opinion that could be considered pejorative, qualify the statement by admitting that this is your inference:

> He *appeared* to be intoxicated . . .
> Her manner *seemed* seductive . . .

Under flow of thought, be sure to mention any abnormalities of association, as well as rate and rhythm of speech. Use examples with direct quotes, both to show the flavor of the patient's speech and to provide a baseline for judging later change.

The findings you report under content of thought will generally reflect what you have already mentioned in the history of the present illness. You should also mention other possible contents of thought that were not present. Whereas many patients have no content of thought that is psychopathological, all (except those who are completely mute) do say something. Whatever it is, you should describe it briefly:

> The patient's content of thought largely concerned his past infidelities and the fact that his wife was about to leave him. He expressed no delusions, hallucinations, obsessions, or phobias.

When your patient has language deficits, state what they are, but also give an example of what you mean:

> Although Mrs. Treat was able to comprehend simple instructions and spoke with good fluency, she demonstrated a naming aphasia: She could not name the clip and point of a ballpoint pen, and she called my wristwatch "a time thingy."

In reporting cognitive abilities, it isn't sufficient simply to mention that the patient was "normal" or "intact." You should note what tests you made, what responses were given, and how you interpret the responses. How far off were any incorrect responses? Do circumstances mitigate the errors? For example, if your patient could not recall a name, a color, and a street address after 5 minutes, can this be explained on the basis of poor concentration due to depression? Was abstracting ability impaired? If so, what was the test you used, and what was the response? In reporting serial sevens, note the number of mistakes and the rapidity with which the calculations were done. Did the patient use finger counting as an aid to calculation?

In reporting insight and judgment, you will usually have to make an interpretation (such as excellent, good, fair, or poor), but be sure to cite your reasoning:

> Miss Rafael's insight seemed poor in that, despite her clearly manic symptoms, she denied ever being ill a day in her life. However, her judgment was fairly good: She did agree to remain in hospital "for tests." She even said that she might resume taking her lithium.

RECORDING YOUR DIAGNOSIS

In North America, the standard for psychiatric diagnosis has been each successive edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association. Much of the rest of the world uses the *International Classification of Diseases* (ICD) in one of its many iterations; it is similarly grounded in research and the opinions of experts. The DSM, devised by committees of experts and strongly grounded in empirical research, specifies that each patient be assessed in several areas.

- The first includes the major clinical syndromes; most mental health patients will have at least one of these diagnoses. These syndromes include the depressions, psychoses, anxiety disorders, substance use disorders, and other clinical entities that mental health clinicians diagnose

and treat, as well as intellectual disability and the personality disorders. If more than one diagnosis is appropriate, include them all, but list first that which was mainly responsible for the current evaluation.

• A statement of any physical diagnoses that contribute to your understanding of the patient—for example, asthma, diabetes, obesity, and temporal lobe epilepsy—helps the reader understand all of this patient's medical problems.

• The psychosocial stressors that during the past year may have caused or affected the patient's mental condition, or might materially affect treatment, come next. Table 5.1 in Chapter 5 of this book lists the types of stressors that may be noted. Write down the exact stressor responsible, not the category.

• The Global Assessment of Functioning (which was included in DSMs up through DSM-IV-TR, and which I still recommend even though it has been omitted from DSM-5) rates the patient's overall functioning. Two ratings can be made: one that is current, and one that describes the highest level of functioning during the past year. The scale runs from 100 (superior) to 1 (lowest). You can find it in my book *DSM-5 Made Easy* or by searching the Internet.

FORMULATION

In the case formulation, you attempt to synthesize all that has been learned about the patient's past, so as to point the way to a better future. There are several reasons for preparing a formulation:

To focus your thinking about the patient

To summarize the logic behind your diagnoses

To identify future needs for information and treatment

To present a brief summary of the patient

A number of formats can be used; some of them are so involved that they risk presenting again all the material you have just covered. The method presented here combines the advantages of brevity, completeness, and simplicity.

Of the various sections of the formulation, the two most important are the differential diagnosis and the contributing factors. They contain the original thinking you will do in putting together all the material you have gathered.

A sample formulation, presented piecemeal, follows.

Brief Recapitulation

Following some minimal identifying data, state the symptoms and course of the patient's present illness as based on the facts in the history of the present illness and the mental status examination. Draw from all parts of your report as needed:

> Mrs. Juneau is a 27-year-old married woman with two previous hospitalizations for a psychosis that has been previously called schizophrenia. For 3 weeks she has stayed in her room, fasting and "preparing for the end of the world," which she says she has caused. Her husband brought her to the hospital when he became concerned about her weight loss.

Differential Diagnosis

Each of the possible diagnoses in your differential listing is presented with the principal arguments for and against it. Mention all possible diagnoses, including personality disorders.

> *Neurocognitive disorder with psychosis (delusions).* History of head trauma 8 years ago.
> *Substance use*. She drank heavily during her two psychotic episodes, but has never continued drinking once the psychosis has resolved.
> *Depression*. Mrs. Juneau feels sad, hopeless, and guilty for some unspecified sin she committed before she was married. She is anorectic, has been nearly sleepless, and has had a 10-pound weight loss.
> *Schizophrenia*. She is delusional now; during a previous episode she believed that she was put on earth to save the Jews.

Best Diagnosis

State the diagnosis you favor, why you have chosen it, and the authority (the current edition of either DSM or ICD). Note that your best diagnosis may not appear highest in the hierarchy. The most notable example of this is that a neurocognitive disorder, if one is possible, must always be ruled out first, but it frequently is not the most likely diagnosis:

> Mrs. Juneau is probably in the depressed phase of bipolar I disorder (DSM-5). Her previous episodes of psychosis resolved completely; her husband reports that even without maintenance medication, she was well between episodes. All of her psychotic symptoms appear to be congruent with her mood at the time. Head trauma was 8 years ago and without sequel, and there are no other indications of organicity. Her misuse of alcohol appears to have occurred only in response to her psychotic episodes, which in retrospect were probably mania with psychosis.

Contributing Factors

Here you describe how the various factors you have identified contributed to the development of your patient's main problems. Where applicable, mention biological, dynamic, psychological, and social factors. Depending on the material you have identified, this section could be long or short:

> A biological basis for Mrs. Juneau's illness may be seen in the family history: Her mother suffered from recurrent depressions. A psychological precipitant may be the death of her father 2 months ago. Medical expenses from previous episodes may be contributing to the depth of her current depression.

Further Information Needed

Briefly cover the interviews, tests, and records you may need to firm up the diagnosis:

> Records will be requested from Mrs. Juneau's previous admissions to see whether the symptoms she had then could be those of mania. Consider MRI to rule out sequelae of old head injury.

Treatment Plan

Outline your recommendations for treatment. For Mrs. Juneau, they would be as follows:

Biological
- Lithium 900 mg/day to prevent recurrence of mania
- Fluoxetine 20 mg/day for depression
- Olanzapine as needed to control psychosis

Psychological
- Psychotherapy, focused on feelings of guilt and grief

Social
- Assistance with financial planning
- (?) Referral to Alcoholics Anonymous
- Education of Juneau family regarding bipolar I disorder

Prognosis

What is the likely outcome for this patient?

> I expect Mrs. Juneau to recover completely. Prophylactic use of a mood stabilizer may prevent subsequent episodes.

THE ORAL PRESENTATION

An oral presentation of your interview material generally follows the same pattern as the written report. Usually it is briefer; in fact, any oral presentation longer than 5–6 minutes risks boredom and inattention. However, you should present a complete, rounded portrait that demonstrates how well you understand the patient.

You can also demonstrate how well organized you are. For a formal presentation, outline your findings on a small note card. This will speed you through your presentation, jog your memory when needed, and save you the discomfort of flipping back and forth through your patient's chart as you search for items of information.

When you are making an oral presentation, be prepared with your diagnosis and differential diagnosis. You should have clearly in mind the reasons for choosing your best diagnosis; some instructors will ask you to defend it with data and logic.

CHAPTER 21

Troubleshooting Your Interview

To some degree, every interview has flaws, and every interviewer has faults. The art of the expert interview lies in compensating for the former and minimizing the effects of the latter. In this chapter, we'll look at some of the problems beginning interviewers often face—or should face, once they become aware of them.

Of course, an initial evaluation can go awry in many ways, but the outcome can be affected in only a couple of ways. Rapport with the patient probably least often falls victim to problematic interviewing; if there is one area in which most clinicians succeed, it is forming a good working relationship with their patients. Still, missteps in the interview process do occasionally lead patients to withdraw from treatment.

The other effect of an interview that's run aground involves the data we seek. That is, we clinicians sometimes obtain information that we think is accurate and complete, when it is not. The initial interview is the time when we consciously try to learn the pertinent facts about a new patient. Regardless how much we may think we have learned, we tend to form an impression after that first information-gathering phase, whether it lasts just an hour or extends over several sessions. Once we've formed a diagnostic impression, we may find it difficult to revise our first impressions, even in the face of compelling later information.

RECOGNIZING THE TROUBLED INTERVIEW

The good news: Most interview situations can be retrieved, once you've figured out what's wrong. The bad news: It can be hard to know what's wrong. Here are some signals that could tip you off.

During the Interview

Even while you are talking with the patient, you should be alert for behaviors signaling that an interview is in trouble.

- The patient becomes quiet, quarrelsome, or critical. Most interactions with patients start out well enough; along the way, though, something occasionally happens to sour a patient on the process. A change in the patient's manner provides the evidence. Someone who was at first cooperative and talkative begins to argue about your seemingly noncontroversial statements. Another, initially loquacious, stops offering spontaneous comments or responds to open-ended questions with single syllables or grunts.

- Although a patient who glances around the room may be attending to hallucinations, it is more likely that this patient has lost interest in the conversation and would like to be doing something different. I've even known patients who bolted from the room, leaving the interview unfinished. Any signal of inattention is important: Without the patient's active participation, what information you obtain isn't likely to be robust, let alone accurate.

- You get contradictory answers to repetitions of essentially the same question.

- You find that you cannot think of questions to ask that will pin down an important part of the differential diagnosis.

- Your patient continually asks you to repeat your questions.

- *You* want to get up and leave the room.

After the Interview

Once your patient has departed, other evidence may tell you that something is awry.

- You find that you have omitted important data points.

- The patient declines to make another appointment.

- Information you've just gathered contradicts data from old charts or collateral sources.

- Your information speaks only to one item in the differential diagnosis.

- You've learned a lot about baseball, but little about the patient's history.

- You haven't learned enough about the patient's feelings.
- You haven't raised one of these issues critical to every interview: sex, substance use, suicidal ideas.

HOW TO DETERMINE WHAT'S WRONG

The following diagnostic steps can help you determine what's wrong with your interview. Even if you haven't encountered any of the issues I've mentioned above, I recommend taking the fearless first step once in a while, anyway. After all, the most insidious error of all is the one that isn't called to your attention.

Make a Recording

Of course, you can only record an interview with your patient's express permission, but this seldom presents a barrier. You can explain that you are trying to learn more about the interviewing process, and that recording an interview will give you a better feel for your patients' needs. I wouldn't feel at all backward about admitting—at your level of experience or at mine—that you would like to learn what you need to learn. In my experience, only a small minority of patients will decline permission to be recorded.

A small recorder placed unobtrusively between the two of you on your desk will do the job nicely. If the room is relatively quiet (there are no loud sounds from the hallway and the heating system behaves itself), you should be able to pick up both voices without difficulty. In the event that there is too much ambient noise, a pair of clip-on microphones joined by a "Y" connector should yield instant clarity.

A video recording would be even better—if you can mount the camera so that it shows both your patient and you. (For sound clarity, you'll also need microphones not mounted on the camera.) You will be interested not only in the patient's appearance, but in your own facial expressions and other elements of body language. Do you frown, squint, look bored, or roll your eyes? Or just fail to smile an occasional encouragement? Do you maintain eye contact, or do you spend all your time scribbling notes? The tool in Appendix E can give some additional structure to your self-assessment.

Do Some Witnessed Interviews

As powerful as your own audio or video recording can be, you can multiply its effectiveness with a little outside help. For generations, the

witnessed interview has been a standard means of validating a psychiatrist's fitness for board certification. By begging an hour or more of a colleague's time, you can get the same benefits for yourself—without the live-or-die trauma that board candidates suffer. Of course, you could have your consultant sit in while you interview a patient new to you, but that would entail coordinating the schedules of three people, not to mention the problem for your patient of having someone else physically present in the room while you are doing an evaluation. It's generally more efficient to use one of the recordings we have just talked about as the basis for a discussion with your local expert on interviewing. (Be sure your patient agrees that another clinician can have access to the material.)

However, finding an appropriate consultant presents one or two problems of its own. A good choice would be someone you know well enough to ask a favor of—but not too well. You need a clinician who will be willing to tell you exactly what's wrong, without worrying too much about offending you. (Candor has much to recommend it in a consultant, so try to find one you know will be frank.) Ask someone with a lot of interviewing experience—perhaps a teacher from your training program, even if you have already graduated. You really need someone who will take the time to listen to (or watch) an entire interview and give you a half-hour or so of feedback on your style. It might even be a clinician of a discipline different from your own; the experience and the perspective are what you're after, not some theoretical stance. Such a person is worth a lot to you, especially if you have been experiencing difficulty with many of your interviews.

WHAT YOU'LL LEARN (AND WHAT TO DO ABOUT IT)

Besides forcing you to confront your verbal tics (it's painful, trust me), the methods described above can reveal difficulties across the spectrum of interview behaviors we've discussed. Here are a few that could show up; the page numbers will take you to the sections of this book that discuss the behaviors you should be practicing.

- *Scope of interview too limited*. It is easy to focus on one or two central questions—severe mood disorder and psychosis come to mind—and leave unexplored issues that might seem more peripheral, but are important anyway. Two examples are marital/family problems resulting from substance use, and personality issues, which can complicate just about any major diagnosis. Free speech is one way to ensure wide coverage. Page 200.

- *Insufficient follow-up of clues*. You risk error if you don't explore clues dropped along the way. Let's say that your patient says, "I was pretty

much running wild those years Dad was gone from the family." You might well pursue what the patient means by "running wild," thereby obtaining a lot of information pertinent to conduct disorder and childhood learning difficulties. But did you remember to ask why Dad was out of the family? Whatever you learn—divorce, a jail sentence, admission to a mental hospital, running away with the babysitter—could be important for your diagnosis. Page 54.

• *Inadequate use of open-ended questions.* When you do identify an area for further exploration, the questions you use can prove critical to the amount and quality of the information you obtain. If you hear about being "abused as a child," you might ask a dozen questions about who hit your patient, when, and under what circumstances, and never learn that your patient was suffering from sexual abuse too. As your expert consultant could tell you, a better approach would be first to ask some open-ended question, on the order of "Please tell me more about that." That way, you'd avoid prematurely closing off an important area of inquiry. As a bonus, open-ended questions would be more likely to reveal something about the emotional consequences of these experiences. It is a common fault for interviewers to become so intent on nailing down certain information that they neglect utterly to give patients enough scope to freely divulge their foremost concerns. I especially find this early in interviews, when there isn't enough (or any) time allotted for free speech. Pages 55 and 64.

• *Inappropriate probing.* However, once you've gotten to know what's foremost in your patient's mind, you'll need specific information about these areas of concern. With poorly chosen probes (questions that are too long, too vague, or phrased in the negative), you could bog down in a mire of trivia or get lost down a rhetorical dead end. "Why . . . " questions invite speculation that may get you exactly nowhere. Instead, focus on probes that encourage precision, brevity, and accuracy. Page 57.

• *Inadequate control of the interview.* A loquacious or hostile patient can reduce your rapport and the amount of information you obtain. Of course, this won't often be a problem; most patients try to cooperate. But your recorded interview could make you instantly appreciate how some patients with certain character or behavior quirks will fight you for the driver's seat. If you lose that battle, you may find yourself at a destination miles from where you need to be—knowing, perhaps, quite a lot about the patient's disrespectful son-in-law or a spouse's drinking, and too little about the patient's own symptoms and personality. Page 116.

• *Poor rapport.* By the end of your recording, you should have a pretty good grasp of how well you've connected with your patient. You'll know whether you sound warm, whether you respond with interest to features of the story, and whether you express concern when you hear about issues

that especially trouble your patient. If you have any doubts, ask your consultant, whose objectivity can inform you about a sensitive issue such as this one. Pages 26 and 120.

• *Ignoring the patient.* OK, maybe *ignoring* is too strong a term. But an initial interview may come to grief because the clinician, so intent on obtaining the needed information, pays too little attention to the patient's needs. The result: As time wears on, the patient becomes more and more restive, and finally bolts from the room before the interview can be completed. Then the bottom line might be no further chance at an interview with this—or perhaps any other—clinician. How much more satisfactory it is to watch for the little signs of increasing concern: jiggling of a leg, twisting of fingers, decreasing eye contact, or increasing hesitation before replying. A timely "It looks to me like you are feeling uncomfortable; how would you like to proceed?" could save the interview, and probably your relationship with this patient. Page 198.

• *No real plan for the interview.* Early in my career, a clinician who had just failed his boards approached me for help. A single practice interview told me that this psychiatrist had gotten though training without ever learning how to obtain the data necessary to support a diagnosis. This clinician needed to use a semistructured interview like that in Appendix D, at least until he was familiar enough with the routine to discard the training wheels. (I hasten to point out that even today, I sometimes use parts of a semistructured interview, as a reminder to inquire into the fine points of a diagnosis or details of a social history.) Page 327.

• *Your own excessive talking.* If your recording reveals that you spend a lot of time talking—perhaps asking complicated questions and then having to explain what you mean—you aren't getting the maximum information out of your interview. Nonverbal encouragements can help; so can carefully formulating your questions. Pages 37 and 57.

• *Negative countertransference.* Sometimes you just won't like a particular patient (or type of patient). Your recorded interview can reveal (perhaps better to your consultant than to you) how much rejection your speech and body language project. Personal preferences can affect any interviewer, even one who has been at it a long time. However, most experienced clinicians learn to put aside their feelings long enough to get the diagnostic information they need; later, if necessary, they can refer such a patient for continuing care. It might help you get past some of your feelings if you practice with a colleague who plays the role of this sort of patient. Even recognizing your attitude can go a long way toward helping you disguise feelings that, though perhaps perfectly normal and understandable, are unacceptable in the context of a mental health evaluation. Page 28.

• *A matter of misunderstanding*. Perhaps the patient just isn't paying attention, but could it be instead that your use of clinical jargon creates confusion? Or maybe you and the patient come from different cultures or speak with different accents. The problem of cultural influence, which nearly every clinician faces at least occasionally, can often be dealt with by frankly discussing your differences and working hard to lower the fences between you. Even when one of you speaks the other's language relatively well, an interpreter may sometimes be useful. Pages 31 and 227.

• *Time running out*. I almost wrote, "Not managing your time well," but that may not be the case. Sometimes the story is too complex, the patient arrives late, or the time allotted is too brief to cover completely all the major areas of a complicated mental health history. Then you'll just have to schedule additional evaluation time; getting on with treatment recommendations without as complete a database as possible has, well, little to recommend it. Page 7.

• *Playing favorites with diagnoses*. Here's a typical example, too often repeated: Based on information from the patient's internist, a clinician decides on a diagnosis of major depression and begins antidepressant therapy—drug therapy happens to be this clinician's special area of expertise. Later, when a consultant suggests that this patient could have a form of somatization (somatic symptom) disorder, the treatment doesn't change. The pattern of the patient's actual symptoms, not your expectations, should determine your diagnosis. Pages 87 and 238.

• *Leaping to conclusions*. There are innumerable areas where this can be a problem, but let's mention one specifically: making a family history diagnosis. The questions you do or don't ask about a relative who was diagnosed with schizophrenia—At what age? What were the symptoms? How long did they last? Did the relative ever recover?—can turn your thinking in the wrong direction about your patient. It's an even slipperier slope if you simply accept a previous clinician's diagnosis of your new patient. Your recorded interview may reveal that you haven't independently verified conclusions relayed to you from patients, relatives, or old records. Page 87.

• *Neglected differential diagnosis*. Your differential diagnosis didn't encompass all the possibilities, no matter how unlikely. As a result, you risked treating the patient's depression conventionally, without considering the possibility that an endocrine disorder is what's responsible. Page 238.

• *Unfamiliarity with diagnostic criteria*. To nail a diagnosis, the first thing you need is nails. In the case of a mental health diagnosis, that means having more than a nodding acquaintance with the essential features of the various psychoses, anxiety disorders, mood disorders,

substance use disorders, and other likely major mental conditions. That way, you don't forget to ask questions that will allow a firm, accurate diagnosis. Page 288.

• *Slighting personal and social history*. It's a mistake when general physicians and surgeons don't obtain information pertaining to a patient's personal background; when a mental health professional commits such an error, it carries the potential for calamity. Sure, in the chase for symptoms of mania or anxiety disorders, it's easy to forget the quiet issues such as childhood relationships or success in school. Nevertheless, this material can have consequences for diagnosis and treatment, and it is always a part of getting to know the patient as a whole person. Page 78.

• *Ignoring red flags*. The varied signs and symptoms that could tip you off to a diagnosis may include something that fairly screams at you: a whiff of childhood abuse, a parent with mania, or an arrest for drug possession. Of course, red flags sometimes become red herrings that don't provide material important to a diagnosis, but you'd hate to be the clinician who overlooks one that proves decisive. Page 160.

• *Forgetting about feelings*. Of course it shouldn't ever happen, but of course it sometimes does. In the rush to obtain all the facts of the history, you forget to ask how the patient feels about a given situation, or even about that person's current emotional state. This is especially likely in the case of a patient who doesn't like to talk about feelings or isn't in touch with them much at all. Page 62.

• *Tolerating vagueness*. A vague patient is a frustrating patient, as long experience has made me all too aware. Confronted with someone whose speech wanders, it is tempting to relax and let it wash over you. If that's been your reaction to some patients, you've probably come away with less in hand than you need for an accurate diagnosis. Closed-ended questions and repeated requests for precision can help. Pages 118 and 210.

• *Neglecting collateral sources*. A good 10% o f the time, I learn something about a patient that makes me wonder, "Is the impression I'm receiving correct?" But so often, the press of time seduces us into accepting what appears to be the case, without making use of the simple expedient of collateral information to check it out. Quite frankly, that's where the couple and family therapists have the advantage: They always obtain their information from more than one source—a self-correcting process that other clinicians can but envy. Page 191.

The many other difficulties you could encounter are limited only by the number of patients you evaluate. By one of the methods described earlier, you should be able to learn the source of the problem and, using material from this book, figure out an appropriate remedy.

APPENDIX A

Summary of the Initial Interview

Information	*Process*
Openings and Introductions	
Introduce yourself Explain your role in patient's care Outline time, goals of interview	Your initial goals Teach respondent role to patient Help patient feel comfortable
Chief Complaint	
Ask why patient came for treatment	Request for chief complaint is directive but open-ended
Free Speech	
Allow several minutes for patient to amplify reasons for coming Listen for areas of clinical interest Difficulty thinking (cognitive problems) Substance use Psychosis Mood disorders (depression and mania) Anxiety, avoidance behavior, and arousal Physical complaints Social and personality problems Summarize presenting problems before moving on	Early part of interview is nondirective Establish rapport Adjust your demeanor to patient's needs Monitor your feelings Show your positive affect clearly Use language patient can comprehend Don't criticize patient or others Maintain appropriate distance Don't talk about yourself Call patient by title and last name Encourage flow with silent encouragements Maintain eye contact Nod or smile when appropriate

Information	*Process*
	Verbal encouragements "Yes" or "Mm-hmm" Repeat patient's own word or words Ask for more information Re-request information if patient doesn't respond at first Briefly summarize Reassure patient when indicated Must be factual, believable Use body language Correct any misconceptions about physical, mental symptoms

History of the Present Illness

Describe symptoms Type Onset Severity Frequency Duration Context Stressors Vegetative symptoms Sleep Appetite and weight Diurnal variation Previous episodes When What symptoms? Recovery complete? Previous treatment Type Compliance Wanted effects Side effects Hospitalizations Consequences of illness Marital and sexual Social Legal Job (disability payments?) Interests Discomfort Feelings about symptoms, behavior Negative and positive	Establish the need for truth It's for patient's benefit and for yours Reassure about confidentiality: "If you can't discuss something, don't lie; just ask to talk about something else" General principles Restate what patient says to be sure you understand Don't phrase questions in the negative Avoid asking double questions Encourage precision Keep questions brief Watch for new leads Use terms patient can understand Probe for details Use direct questions Avoid "Why . . ." questions, as a rule Limit to one or two confrontations, late in session: "Help me to understand" Mix open- and closed-ended requests Open-ended increase validity Closed-ended increase information Elicit feelings best with: Uninterrupted speech Open-ended questions—"Could you tell me more about that?"

Information	*Process*
How does patient cope with feelings?	Direct requests for feelings—"Tell me about your depression"
Defense mechanisms	Also obtain feelings with:
Acting out	Express concern or sympathy—"I'd feel angry, too"
Denial	Reflection of feelings—"You must have felt frantic"
Devaluation	Watch for emotional cues in voice, body language—"You looked sad just now"
Displacement	Interpretations—"Sounds like the way you felt as a child"
Dissociation	Analogy—"Did you feel this way when your mother died?"
Fantasy	Reduce excessive emotionality:
Intellectualization	Speak softly yourself
Projection	Use closed-ended questions
Repression	Redirect comments that change topic
Splitting	Re-explain what information you need
Reaction formation	Ask whether patient understands what you want to know
Somatization	Break off interview only as last resort
Explore areas of clinical interest	

Personal and Social History

CHILDHOOD AND GROWING UP	Take charge of interview
Where was the patient born?	Encourage shorter answers with nods and smiles
Number of siblings and sibship position	Directly state when you need to know about something different, but . . .
Reared by both parents?	Make an empathic comment first
How did parents get along?	Raise a finger to interrupt
Did patient feel wanted as a child?	Stop taking notes
If adopted	If above steps don't work:
What circumstances?	Be direct: "We'll have to move on"
Extrafamilial?	Use more closed-ended questions
Health as a child?	Use multiple-choice questions
Education	Transition to new topics
Last grade completed	Use patient's own words
Scholastic problems?	Acknowledge an abrupt transition: "Let me change the subject, now"
Activity level?	Watch for distortion
School refusal?	
Behavior problems in school?	
Suspensions or expulsions?	
Sociable as child?	

Information

Age dating began?
Sexual development
Hobbies, interests

LIFE AS AN ADULT
Living situation
  Currently with whom?
  Where?
  Finances
  Ever homeless?
  Support network
Family ties
Agencies help out?
Marital
  Number of marriages
  Age at each
  Problems with spouse?
  Number of children, age, and sex
  Stepchildren?
Work history
  Current occupation
  Number of jobs lifetime
  Reasons for job changes
  Ever fired? Why?
Military
  Branch, years of service
  Highest rank attained
  Disciplinary problems?
  Combat experience?
Legal problems ever?
  Civil
  History of violent behavior
  Arrests
Religion: Which? Different from childhood?
  How religious now?
Leisure activities
  Clubs, organizations
  Hobbies, interests
Sexual preference and adjustment
  Learning about sex: details
  First sexual experiences
    Nature
    Age
    Patient's reaction
  Current sexual preference

Process

Record significant negatives

DEALING WITH RESISTANCE
Do not allow yourself to become angry
Switch from discussing facts to feelings
Reject the behavior, accept the person
Use verbal and nonverbal encouragements
Focus on patient's interests
Express sympathy
Reassure patient: Feelings are normal
Emphasize need for complete database
Name the emotion you suspect patient is having
If patient is silent, obtain nonverbal response first
Focus on less affect-laden model of patient's behavior
If confrontation is used: nonjudgmental, nonthreatening
Last resort: Delay the question

RISKIER TECHNIQUES
Offer an excuse for unfavorable information: "All that stress probably made you want to drink"
Exaggerate negative consequences that didn't happen: "Nobody died, did they?"
Induce patient to brag "Any activities for which you could have been arrested, but weren't?"

"Please tell me about your sexual functioning"

Information	*Process*
Current practices: details	
Pleasures	
Problems	
Birth control methods	
Extramarital partners?	
Paraphilias?	
Sexually transmitted diseases?	
Abuse?	Lead into questions of abuse carefully: "Were you ever approached for sex?"
Childhood molestation	
Rape	
Spouse abuse	
	Avoid terms *abuse* and *molestation*
Substance misuse	Assume that all adults will drink some
Types of substances	
Years of use	Ask about past as well as current use
Quantity	
Consequences	
Medical problems	
Loss of control	
Personal and interpersonal	
Job	
Legal	
Financial	
Misuse of prescription medications?	
Suicide attempts	You can work up to this gradually: "Have you ever had any desperate thoughts? Any ideas of harming yourself?
Methods	
Consequences	
Drug- or alcohol-associated?	
Psychological seriousness	
Physical seriousness	
Personality traits	Assess personality by
Evidence of lifelong behavior patterns	Patient's self-report
	Informants
	History of interaction with others
	Your direct observation
FAMILY HISTORY	
Mental disorder in close relatives	"Has any blood relative—parent, brother, sister, grandparent, child, aunt or uncle, cousin, niece or nephew—ever had any mental illness, including depression, mania, psychosis, mental hospitalization, severe nervousness, substance use, suicide or suicide attempts, criminality?"
Describe parents, siblings, and patient's relationship with them	
Other adults, children in childhood home	

Information	*Process*
MEDICAL HISTORY	
Major illnesses	Important for *all* mental health workers to obtain
Operations	
Medications for nonmental problems	
Dose	
Frequency	
Side effects	
Allergies	
To environment	
To medications	
Nonmental hospitalizations	
Childhood physical, sexual abuse?	
Risk factors for HIV/AIDS?	
Physical impairments	
REVIEW OF SYSTEMS	
Disorders of appetite	Positive responses in these areas have especial relevance to mental health diagnoses
Head injury	
Convulsions	
Unconsciousness	
Premenstrual syndrome	
Specialized review for somatization disorder	See Chapter 13
Mental Status Exam	
Appearance	Observed while taking history
Apparent age	
Ethnicity	
Body build, posture	
Nutrition	
Clothing: Neat? Clean? Style?	
Hygiene	
Hairstyle	
Body adornments, jewelry?	
Alertness: Full? Drowsy? Stupor? Coma?	
General behavior	
Activity level	
Tremors?	
Mannerisms and stereotypies	
Facial expressions	
Eye contact	
Voice	
Attitude toward examiner	
Mood	
Type	

Information	*Process*
Lability	Observed while taking history
Appropriateness	
Intensity	
Flow of thought	
Word associations	
Rate and rhythm of speech	
Content of thought	
Delusions	
Hallucinations	
Anxiety	
Phobias	
Obsessions and compulsions	
Suicide and violence	
Orientation: Person? Place? Time?	"Now I'd like to ask some routine questions . . ."
Language: Comprehension, fluency, naming, repetition, reading, writing	
Memory: Immediate? Short-term? Long-term?	"How has your memory been? Do you mind if I test it?"
Attention and concentration	
Serial events	
Count backwards	
Cultural information	
Current events	
Five presidents (prime ministers)	
Abstract thinking	
Proverbs	
Similarities and differences	
Insight	
Judgment	
	Closure
	Summarize findings
	Set next appointment
	"Do you have any questions for me?"

APPENDIX B

Descriptions of Selected Disorders

In this appendix, I give brief descriptions of the typical symptoms and course for those mental disorders that are relatively common and reasonably well studied. It is *always* important to rule out both substance use and general medical conditions as the cause, and to determine that the patient suffers distress or impaired functioning at work or school or getting along with other people.

Please remember that these paragraphs are meant to be descriptive, not diagnostic, of the various disorders. If you need criteria, see appropriate texts (or consult Dr. Google).

MOOD DISORDERS

Depression is an altered mood in which the patient feels abnormally low in spirits, sometimes melancholic. The patient experiences great distress, feels a loss of control over mood, and often has suicidal ideas. Depression can take a number of forms, each of which has been given a name—and sometimes several alternative names. These forms of depression are often overlapping, so that a given patient could actually be classifiable as belonging to more than one category. Here I give prominent features of the more important varieties of depression.

Major Depressive Disorder

- Major depressive disorder involves discrete episodes during which patients usually describe themselves as feeling depressed, though sometimes all they can identify is a feeling of irritability or a loss of enjoyment or interest in activities they usually like. In any case, there is a definite change from the patients' previous level of functioning.

- They also have a number of associated symptoms, including increased or decreased appetite, often with consequent gain or loss of weight; increased or decreased sleep; psychomotor speeding or slowing; fatigue or decreased energy; feelings of worthlessness or guilt; trouble concentrating; and thoughts of death, death wishes, and suicidal ideas.
- These symptoms may be mild, perhaps resulting in only minor inconvenience, though still enough that the patient feels distressed or experiences impaired functioning. When severe, depression can even involve psychosis—serious impairment, indeed.
- A major rule-out is depression due to medical disease or substance use.

Perhaps 25% of depressed patients also have episodes of mania or hypomania, in which case the diagnosis would be bipolar I or bipolar II disorder (see "Bipolar Disorders," below). With no history of mood upswings, a major depressive episode would be diagnosed as unipolar depression (major depressive disorder, either single episode or recurrent).

There's another problem here, one that diagnostic manuals don't do much to clarify. That's the fact that many depressed patients have other major disorders that ought to outrank the depression when it comes to treatment, yet don't. Here's an example: A patient with what I still prefer to call somatization disorder (see "Somatization Disorder," below) may very well also be depressed, and would at one time have been diagnosed with *secondary depression*. It's good to know about this sort of depression because, over the long term, it tends to respond poorly to physical methods such as drugs and electroconvulsive therapy. Another example would be a depression that dogs the heels of substance use.

Melancholia

Officially termed *major depressive episode with melancholic features*, the form of depression traditionally known as melancholia has sometimes been called *endogenous depression* because we cannot identify a precipitating stressor. These patients may have multiple episodes of depression from which they recover completely; they are likely to have relatives who have also suffered from depression.

- When ill, the patients take little pleasure from usual activities and may not cheer up when with people whose company they normally enjoy. They typically awaken early in the morning, well before it is time to arise—and, that's the time of day when they feel worst. Often they eat little; weight loss can be profound. They may demonstrate psychomotor slowing or speeding.
- They will admit that they feel worse than they have felt at the death of a spouse or other relative. They may have little insight into the fact that they are ill: Even if they have recovered completely from previous episodes, they may strenuously deny that recovery is a likely outcome.
- Partly due to feelings of profound guilt, they are at severe risk for suicide attempts; untreated, perhaps 15% ultimately kill themselves.

Atypical Depression

Patients with atypical depression have a major depressive episode—with a twist. Their symptoms are rather the opposite of what you expect from a typical, severe depression.

- Rather than insomnia, they tend to sleep too much (hypersomnia).
- Rather than having anorexia, they eat more than usual (for them) and may gain weight.
- If their mood varies during the day, it is one in which they feel better in the morning, worse at night.
- Depressed or not, these people tend to be especially sensitive to criticism.

Persistent Depressive Disorder (Dysthymia)

- Compared with episodes of major depression, dysthymia is less severe but lasts longer (at least 2 years). Some dysthymic patients seem depressed virtually lifelong.
- They have some of the same symptoms found in "basic" major depression and in melancholia, but the symptoms are fewer and less severe (they have neither psychotic symptoms nor suicidal ideas/behaviors). Although they typically remain able to work and to take care of themselves and their families, they don't much enjoy life. They seldom require hospitalization, unless a major depressive episode supervenes.
- As usual, there must be no question of causation by a general medical disorder or by substance use.

Bipolar Disorders

- The mania of bipolar I disorder usually begins suddenly, with euphoric or irritable mood that is accompanied by overactivity and excessive speech.
- Manic patients are easily distractible, need little sleep, and become involved in grandiose plans and schemes.
- As they become sicker, patients lose insight; judgment deteriorates. They say or do things they later regret, such as becoming sexually promiscuous, spending money they don't have, or making other problematic decisions.
- They may feel abnormally strong or powerful. Some become deluded that they have special powers or have a special religious purpose.
- Many drink excessively; perhaps they're trying to apply chemical brakes to their own behavior.

Most manic patients also have episodes of major depression, which may alternate regularly with the high phases in the pattern known as bipolar I disorder. Some bipolar patients don't have full-blown manias; their "rather highs" comprise somewhat attenuated symptoms that don't lead to psychosis or require hospitalization. This less-serious condition is termed bipolar II disorder. Even without treatment, both types of patients usually recover completely.

PSYCHOTIC DISORDERS

The Schizophrenias

Although schizophrenia is usually referred to as a single disease, in reality this category probably includes several different disorders. Some patients seem perfectly normal before the onset of the actual schizophrenia symptoms, but many spend childhood as introverted loners. Some qualify for a diagnosis of schizotypal personality disorder.

- There is usually a *prodrome* during which an individual may become interested in philosophy, religion, or witchcraft; anxiety or perplexity may be the predominant affect. Isolation may increase, and relatives or friends may note various behaviors that are peculiar, although not exactly psychotic.
- As preoccupation with inner feelings and experiences increases, the patient's functioning at work or school falls off. It may be only at this stage that relatives notice a change. Although orientation is usually retained, insight is typically lost, and judgment is severely impaired. Patients can lose impulse control and, when markedly agitated, sometimes become violent toward self or others.
- Active symptoms usually begin early in life—late teens or early 20s—and increase slowly, over a period of many months. Gradually the *hallucinations* (most often auditory) begin, becoming ever more insistent. *Delusions* (especially persecutory) usually develop. *Negative symptoms* (such as apathy or affect that is blunted, silly, or inconsequential) may appear. *Thought associations in speech* are often loose. Only a few patients develop *disordered behavior* such as catatonic symptoms. From these five classes of symptoms, you need two or more symptoms (and at least one of these must be delusions, hallucinations, or disordered thought/speech) to make the diagnosis.
- The disorder is chronic. A patient must be ill for at least 6 months to receive the diagnosis of schizophrenia in the first place. Then, though treatment with antipsychotic medicine can reduce or eliminate psychotic symptoms, few patients recover to their premorbid levels of functioning.

Patients with schizophrenia were formerly given subtype diagnoses: paranoid, catatonic, disorganized, undifferentiated, or residual. DSM-5 has done away with these divisions, partly because they don't remain constant in an individual. However, it is still sometimes useful to note that patients whose symptoms are pretty much limited to persecutory delusions and auditory hallucinations—which we used to call paranoid schizophrenia—often have affect that is well preserved and don't begin to have symptoms until they are in their 30s, or even beyond.

Warning: Schizophrenia today has carefully delineated symptoms, so be careful not to overdiagnose it. Until a few years ago it was common to see patients with severe depression, mania, personality disorders, or neurocognitive disorders misdiagnosed as having schizophrenia. Even today, it still sometimes happens. Patients who for many years have carried the diagnosis of schizophrenia should

be periodically reassessed. Be especially on the lookout for situations were psychotic symptoms are only present when the patient is experiencing a depressive or manic episode: Such a patient should *not* receive a diagnosis of schizophrenia.

Schizoaffective Disorder

The confusing diagnosis of schizoaffective disorder was introduced in 1933 by Jacob Kasanin, a well-meaning doctor who used it to describe nine patients who had both psychotic and mood symptoms. Because this description could fit so many people (patients with schizophrenia often feel depressed at some time or other), the term took off. In the intervening 80+ years, it has only grown more popular. Now it is used loosely by some clinicians, and very loosely by others: A few years ago, one psychiatrist famously wrote that he gave this diagnosis to most of his patients! Historically, however, the concept is important, in that it helped us understand that not all psychosis is schizophrenia.

- Patients with schizoaffective disorder simultaneously have two of the five major psychotic features of schizophrenia (as above, delusions, hallucinations, disordered thinking/speech, disorganized behavior, and negative symptoms) and *also* have a major depressive or manic episode (or a mood episode with mixed features) during most of the episode.
- For at least 2 weeks, the individual must have had delusions or hallucinations without prominent mood symptoms. You can specify a subtype—bipolar or depressive.

In recent years, numerous reviews have failed to substantiate schizoaffective disorder as a separate, discrete diagnosis. (Indeed, few of Kasanin's original patients would qualify by today's standards.) Both the interrater reliability and diagnostic stability for schizoaffective disorder appear to be low.

Schizophreniform Disorder

No difficulties with criteria present themselves with schizophreniform disorder. That's because this term is really just a place holder—an acknowledgment that a clinician isn't sure enough to make a definitive diagnosis.

- Schizophreniform disorder is defined exactly like schizophrenia, except that its total duration must be less than 6 months. This time frame reflects the findings from study after study that patients who have had psychotic symptoms for briefer periods of time may recover completely.
- Once 6 months have passed, a patient must be rediagnosed. If the symptoms persist, you will probably diagnose actual schizophrenia. If they have remitted, you may change the diagnosis to something different, such as a mood disorder with psychosis or a psychosis caused by a medical illness or by substance use.

If we do use the diagnosis of schizophreniform disorder, we are encouraged to assign prognosis, based on several factors. A patient will be relatively likely to

recover (that is, likely not to progress to a chronic course of illness) if any two of the following features are present: (1) Actual psychotic symptoms begin within 4 weeks of the first observable change in the patient's functioning or behavior. (2) When most psychotic, the patient seems baffled or confused. (3) Job and social functioning were good before the illness. (4) Affect is not constricted.

Delusional Disorder

- Patients with delusional disorder have delusions that are not bizarre (that is, the delusions are *not* impossible, such as being abducted by aliens). However, delusions are the only symptoms they typically have, so they don't qualify for other psychotic diagnoses such as schizophrenia (except that hallucinations of touch or smell may be present if they are related to the theme of the delusions).
- Once this illness develops, it tends to be chronic.
- There is good preservation of mood and ability to communicate; if employed, these people remain able to work. They do have trouble in the social sphere, however, and members of their families often instigate the referral for treatment.

Several types of delusional disorder have been described, based on the nature of the delusions themselves:

Erotomanic. Someone (often one who is famous or of high social station) is in love with the patient. These patients sometimes make the news for following or otherwise harassing public figures.

Grandiose. These people believe that they have some special ability or insight. Some claim to have invented something of great value, and so may haunt government agencies (patent office, police) in pursuit of their plans.

Persecutory. The patient (or a close associate) is being intentionally cheated, drugged, followed, slandered, or otherwise mistreated.

Jealousy. Most often, these individuals believe that a spouse is being unfaithful; a patient may follow a spouse or confront a supposed lover.

Somatic. These patients often seek medical help, convinced that they have a foul body odor, parasites, or infestation of insects on or under the skin, or that some body part is misshapen.

Mixed. The patient has two or more of the themes above in roughly equal portions.

Unspecified.

Psychotic Disorder Due to Substance/Medication Use or to Another Medical Condition

The category of substance/medication-induced psychotic disorder includes all psychoses caused by substances, including prescription medications. The predominant symptoms (hallucinations or delusions) can occur during withdrawal

or acute intoxication, depending on the substance. The course is usually brief and self-limited.

Classic examples of this disorder are alcoholic auditory hallucinosis and the delusional state that sometimes accompanies chronic amphetamine use. The psychotic symptoms may be indistinguishable from those of paranoid schizophrenia. Marijuana, cocaine, inhalants, opioids, phencyclidine and other hallucinogens, and sedatives/hypnotics have also been implicated in these conditions. Be careful not to make this diagnosis if the patient is having an acute delirium.

For medical conditions, the drill is much the same. A great variety of medical illnesses can produce a substantial variety of psychotic symptoms, including a full spectrum of delusions and hallucinations, as well as abnormalities of movement (such as catatonic symptoms) and negative symptoms.

By the way, similar categories (and arguments) hold for mood and anxiety disorders.

SUBSTANCE-RELATED DISORDERS

The terminology keeps changing, but the disorders themselves remain the same: alcohol and drug misuse. The 21st century presents an ever-widening variety of substances that can lead to a form of dependence DSM-5 now calls substance use disorder.

Identification of this dependence is based on the presence of some of these behaviors: tolerance to the drug (the drug has less effect with continued use, or the person must use more of it to achieve the same effect); withdrawal symptoms when the dose is decreased; using more than intended; unsuccessful attempts to control usage; spending much time obtaining or using the substance; reducing important activities because of substance use; failing to follow through on important obligations at work/school or home (such as repeated absences, neglect of children or house, or poor work performances); ongoing use despite knowing that the substance has probably caused physical or psychological problems; use of the substance even when it is physically dangerous to do so (such as driving a car); continuing to use the substance despite knowing that it has caused or worsened social or relationship problems (fights, arguments); and, finally, one nonbehavioral criterion (the person craves the substance or strongly wants to use it).

NEUROCOGNITIVE DISORDERS

Neurocognitive disorders are behavioral or psychological abnormalities that are associated with temporary or permanent brain dysfunctions. The cause can be an abnormality of brain structure, chemistry, or physiology, but the exact etiology isn't always known. Impairment can occur in any of four main areas: intellectual functioning, judgment, memory, and orientation. Some patients also have associated abnormalities of impulse control or mood. The neurocognitive disorders have traditionally been broadly categorized as either delirium or dementia; dementia is now classified in DSM-5 as major neurocognitive disorder.

Delirium

Delirium usually begins acutely, usually caused by something that occurs outside the brain. It tends to fluctuate in intensity and is usually short-lived, resolving once the underlying condition has been relieved.

- Patients cannot focus or maintain attention and are often easily distractible. Their thought processes slow down; they have trouble solving problems and reasoning.
- There is also an alteration in thinking, such as problems with orientation, use of language, executive functioning, memory, learning, or perception (hallucinations). Hallucinations may confuse patients so that they cannot tell whether they are dreaming or awake. They may accept the hallucinations as reality, thereby experiencing anxiety or fear; sometimes they attempt to run away.
- The causes of delirium include endocrine disorders, infection, brain tumor, cessation of alcohol intake, drug toxicity, vitamin deficiency, fever, seizures, liver or kidney disease, poisons, and the effects of surgical operations. Multiple causes may contribute to a single episode.
- The symptoms develop rapidly and tend to worsen at night—a phenomenon called *sundowning*. Later recall for the symptoms may be spotty or nil.

Dementia

Patients with DSM-5 major neurocognitive disorder (or dementia, as I'll usually continue to call it for the sake of brevity) show loss of ability to think and to remember that is severe enough to interfere with work and social life. Dementia can be transient, but more often it persists and progresses, frequently to the point that the patient shows impaired judgment and abstract thinking. Severely demented patients may not recognize family members; they can even become lost in their own homes. Failure of judgment and impulse control can lead to loss of the social graces, as shown by making crude jokes or by ignoring personal hygiene. Ability to use language is usually spared until late in the disease.

The major features of dementia include the following:

- Clinician, informant, and/or patient worry that the patient's cognition has declined from a previous level of performance.
- Standard neurocognitive testing (or an equivalent clinical evaluation) reveals that the patient's performance is more than 2 standard deviations below norms (for major neurocognitive disorder) or 1–2 standard deviations below (for what DSM-5 now calls mild neurocognitive disorder).
- The symptoms limit the patient's independence (for major neurocognitive disorder) or don't (in mild neurocognitive disorder, the patient can compensate with effort).
- The symptoms aren't better explained by a different major mental disorder, and they don't occur only with delirium.

Onset of dementia is usually insidious, and the misconceptions (hallucinations or illusions) so common in delirium are often absent, especially early in

the process. Usually an organic cause can be identified. Causes include primary diseases of the central nervous system, such as Alzheimer's disease, Huntington's disease, multiple sclerosis, and Parkinson's disease; infectious diseases, such as neurosyphilis and HIV/AIDS; vitamin deficiencies; tumors; trauma; and various diseases of liver, lungs, and the endocrine and cardiovascular systems. A few causes (subdural hematoma, normal-pressure hydrocephalus, hypothyroidism) can be successfully treated, leading to full recovery from the dementia symptoms. Dementias are found mainly in older patients, and the course is usually one of chronic deterioration.

A type of dementia that formerly carried its own DSM designation is amnestic disorder, in which patients rather suddenly lose short-term memory, sometimes to the extent that they cannot recall events that took place scant minutes earlier. Remote memory is usually less involved. Many patients confabulate information spontaneously or in response to prompting ("Didn't I see you in the bar last night?"). Recovery can occur, although chronicity is more the rule.

ANXIETY DISORDERS

Warning: Many mentally ill patients have anxiety symptoms as a part of their overall complaints. It is important not to let anxiety symptoms, which may be presenting complaints of many patients, obscure other diagnoses that may be even more important for diagnosis and treatment. In this regard, be especially alert for the presence of depressive syndromes and substance-related disorders.

Generalized Anxiety Disorder

- Patients with generalized anxiety disorder worry unreasonably about *multiple* life circumstances, such as money, family, health, and problems in school or on the job.
- As a result, they have symptoms of anxiety such as feeling restless or edgy, tiring easily, trouble concentrating, irritability, increased muscle tension, and trouble with sleep.
- Because they feel this way most days, they will procrastinate or otherwise avoid situations where they might have these feelings.

Generalized anxiety disorder usually starts in early adulthood; women outnumber men about 2:1. It's encountered especially among patients of internists and general practitioners. Some authorities believe that it may affect 5% of the general population; others hold that it is often misdiagnosed instead of a different anxiety or other disorder.

Panic Attack and Panic Disorder

- The patient experiences discrete episodes of anxiety or fear that begin suddenly and reach their height within minutes. (Just before such an episode, the person could be either calm or anxious.)
- During an attack the patient experiences several typical symptoms, such

as chest pain, hot flashes or chills, choking sensations, feeling unreal or detached from self, dizziness, fear of impending death, fear of "losing my mind," heart pounding or racing or skipping beats, nausea, tingling/numbness (usually of fingers), excessive perspiration, shortness of breath, and trembling.
- When unexpected panic attacks occur repeatedly and the patient is afraid of further attacks or tries to forestall them, we say that the patient has panic disorder.

Panic disorder affects perhaps 2% of all adults; it has a strong genetic component and may be somewhat more common in women than in men. Although it can start at any age, it usually develops in young adults. It is often associated with agoraphobia.

Note that panic symptoms can occur in the course of other disorders—including not only most anxiety disorders, but also substance intoxication, posttraumatic stress disorder, and obsessive–compulsive disorder, among others.

Agoraphobia

Agoraphobia originally meant "fear of the marketplace," but it now comprises fears of being in any place or situation where it might be hard to escape or to get help.

- The patient thus might avoid leaving home, markets, shops, open places, public transportation, theaters—even standing in a line or crowd.
- For 6 months or more, the patient therefore avoids the feared situations or needs a companion or suffers discomfort when confronting them.

Agoraphobia affects relatively few of us (perhaps 1 in 200 adults), women more often than men. It typically starts early in life following a panic attack or a traumatic event. Most patients with agoraphobia also have panic attacks; however, the two diagnoses can be made independently.

OBSESSIVE–COMPULSIVE DISORDER

Obsessive–compulsive disorder is a well-studied illness that begins in the teens or 20s and often persists lifelong.

- These patients have obsessions or compulsions (or both) that come unbidden into awareness, accompanied by anxiety or dread.
- Patients invest a lot of time and effort in these distressing ideas or behaviors, which seem foreign (ego-alien), silly, or irrational to them.

Usually there is insight that these ideas are products of the patient's own mind, but occasionally it can be completely absent. The main compulsive patterns include handwashing, cleaning, and compulsive checking to be sure that some action (such as turning off the stove) has in fact been accomplished. The patient feels driven to

complete these actions, which are geared toward reducing anxiety. Symptoms of depression are common. In some patients, there is a tie-in to lifelong tics.

POSTTRAUMATIC STRESS DISORDER

Posttraumatic stress disorder is a modern diagnosis comprising what was once called *shellshock* or *combat fatigue* in soldiers. It is a common sequel for anyone who has experienced rape, combat, or any other major naturally occurring or human-made calamity (earthquakes, airplane crashes) that involves actual or threatened death or injury. (The experience can be vicarious if it occurs to a close friend or relative.)

For at least a month the patient:

- Relives the traumatic event through intrusive dreams or waking thoughts.
- Avoids reminders of the event.
- Experiences negative emotions ("no future," self-blame) and altered cognitions (such as amnesia).
- Endures symptoms of hyperarousal (hypervigilance, increased startle response).

It may take weeks or years to develop symptoms, which often fluctuate over time. Severity is usually proportional to the intensity of the traumatic event. The condition is more likely to occur in children, elderly persons, and those who are socially isolated.

ANOREXIA NERVOSA

- Patients with anorexia nervosa feel that they are overweight when they are not. Even when emaciated, they perceive themselves as overweight and fear becoming fat.
- They severely limit food intake, sometimes to the point of malnutrition and (in females) the cessation of normal menses.

Patients may abuse diuretics and laxatives; some vomit to maintain low weight. Severe symptoms can lead to death. This disorder is relatively common (up to 0.5%) among young females, but occurs only about one-tenth as often in males.

SOMATIZATION DISORDER

Affecting perhaps 1% of adult women (rare in men), somatization disorder is characterized by multiple somatic complaints. Suspect it in anyone who presents a complicated or vague history; responds poorly to treatment; is dramatic, demanding, or seductive; has a family history of personality disorder; was abused sexually as a child; misuses substances; or has depression with unusual features. Many of these patients attempt suicide. This diagnosis is often overlooked even by mental health professionals.

The exact nomenclature and diagnostic criteria for this disorder have changed markedly over the past 50–60 years. In the middle of the 20th century, criteria were devised to clearly identify what was then called *Briquet's syndrome*, and to differentiate it from the hoary diagnosis of *hysteria*, which basically depended on only one criterion: that the person have a symptom apparently not due to any organic disease state. Beginning in DSM-III and continuing through DSM-III-R, DSM-IV, and DSM-IV-TR, criteria for somatization disorder spelled out sets of physical symptoms, of which certain numbers and distributions were required for diagnosis. These symptom lists were long and somewhat clumsy to use, and the suspicion that they were widely ignored by clinicians helped fuel the steady reduction in the minimum number of required symptoms.

However, DSM-5 has now stepped back to a point where patients can be diagnosed with the most recent iteration—now termed somatic symptom disorder—if they have basically a single physical symptom. It must last at least 6 months, and there must be evidence of inordinate ongoing health concern; even so, one symptom will do the job. I am deeply concerned that this retrograde step will reduce our understanding of a group of patients who have been misdiagnosed and incorrectly treated throughout the history of medicine. Nonetheless, here are the characteristics of DSM-5 somatic symptom disorder.

- For 6 months or more, at least one somatic symptom has caused distress or disruption of daily life.
- As a result, the patient has continuing high anxiety about health concerns.
- *With predominant pain* can be added as a specifier if the patient's presenting problem is mainly complaint of pain. (DSM-IV considered this a separate diagnosis and called it pain disorder.)

As a counterpoint, I've appended below the original criteria for Briquet's syndrome. It allowed diagnosis of patients who had mental/emotional symptoms as well as physical ones, and helped differentiate those with depression who might be less amenable to medical treatment from those who might benefit from drugs or electroconvulsive therapy. Furthermore, in the "Physical Complaints" section of the Appendix D structured interview (p. 338), I've used the DSM-IV criteria for somatization disorder—the disorder name I have generally chosen to use in this book. Consistency hasn't been the hallmark of mental health diagnosis over the years, so "you pays your money and takes your choice."

Briquet's Syndrome

- Beginning by age 30, the patient is chronically or recurrently ill with a dramatic, vague, or complicated medical history.
- The patient must report at least 25 medically unexplained symptoms (20–24 for a "probable" diagnosis) in 9 or 10 of the following categories:

    1. Headaches; being sickly for majority of life
    2. Blindness, paralysis, anesthesia, aphonia, fits or convulsions, unconsciousness, amnesia, deafness, hallucinations, urinary retention, trouble walking, other unexplained "neurological" symptoms

3. Fatigue, lump in throat, fainting spells, visual blurring, weakness, dysuria
4. Breathing difficulty, palpitations, anxiety attacks, chest pain, dizziness
5. Anorexia, weight loss, marked fluctuations in weight, nausea, abdominal bloating, food intolerances, diarrhea, constipation
6. Abdominal pain, vomiting
7. Dysmenorrhea, menstrual irregularity, amenorrhea, excessive menstrual bleeding
8. Sexual indifference, frigidity, dyspareunia, other sexual difficulties; vomiting all 9 months of pregnancy at least once, or hospitalization for hyperemesis gravidarum
9. Back pain, joint pain, extremity pain; burning pains of sexual organs, mouth, or rectum; other bodily pains
10. Nervousness, fears, depressed feelings; need to quit working or inability to carry on regular duties because of feeling sick; crying easily, feeling life is hopeless, thinking a good deal about dying, wanting to die, thinking about suicide, suicide attempts

PERSONALITY DISORDERS

DSM-5 lists 10 personality disorders that are defined well enough to achieve formal recognition. For 6 of them, studies have been robust enough to have a decent level of validity. I've characterized them below. In each of these personality disorders, the attitudes and behaviors are present from early adult life (sometimes much earlier) and are experienced in a variety of situations.

Schizotypal Personality Disorder

Magical thinking, ideas of reference, illusions or other unusual perceptions, and sometimes unusual mannerisms or clothing can make patients with schizotypal personality disorder seem quite odd. They may mistrust other people's intentions, leaving them isolated and anxious or otherwise uncomfortable with ordinary social relationships. Though some do marry, they typically doubt the loyalty of others and have few close friends. Their thinking may be dominated by suspicions and superstitions, which are expressed with restricted affect and speech that is vague, digressive, or excessively abstract.

Many patients with schizotypal personality disorder are depressed when they first come to clinical attention. Under stress, patients may become briefly psychotic; some eventually develop schizophrenia, a diagnosis that is more frequent in their relatives than in the general population.

This disorder occurs in up to 3% of the general population.

Antisocial Personality Disorder

Although patients with antisocial personality disorder often seem charming personally, from youth (generally beginning before age 15) they cannot follow

society's rules. Their relationships with others are characterized by exploitation rather than by mutual intimacy. These people may glibly claim to have guilt feelings, but empathy and genuine remorse aren't in evidence.

Their sense of self derives from exerting power over others or from personal pleasure or material gain; the result is callous and irresponsible behavior that affects nearly every life area. There may be substance use, fighting, lying, and dishonest (often criminal) behavior of any conceivable sort: theft, violence, confidence schemes, and child/spouse abuse. Much of their aberrant behavior is impulsive, often without real need or consideration of the possible consequences for the risk they take. Although they may complain of multiple somatic problems and will occasionally make suicide attempts, the manipulative nature of all their interactions with others makes it difficult to decide whether their complaints are genuine.

Two warnings for this one: Although patients with antisocial personality disorder often have a childhood marked by incorrigibility, delinquency, and school problems such as truancy, fewer than half of all children with this sort of background eventually develop the full adult syndrome. Therefore, this personality disorder should never be diagnosed before age 18. It is also important not to diagnose it if antisocial behavior occurs only in the context of substance use.

Borderline Personality Disorder

Patients with borderline personality disorder often appear to be in a crisis of mood (depression, anxiety, or fear), behavior, or interpersonal relationships. Feeling empty and bored, they will attach themselves strongly to others. This doesn't work so well: Inevitably they fear they are being ignored or mistreated (or fear abandonment) by those upon whom they feel dependent, and so become intensely angry or hostile. They may impulsively try to harm or mutilate themselves. Other rash actions may form a pattern of risk taking or of too-frequent, too-extreme shifts from one life goal to another.

Although unusually sensitive to possible insults toward themselves, these patients may remain oblivious to the feelings and needs of others. Indeed, they are likely to emphasize other people's faults. Regard for another person may be idealized at one time, devalued at another, resulting in alternating enmeshment and withdrawal.

Patients with borderline personality disorder tend to be markedly self-critical, sometimes to the point of dissociating when under extreme duress. However, any dissociative or psychotic episodes resolve so quickly that they are seldom confused with the endogenous psychoses. Intense, rapid mood swings, impassivity, and unstable interpersonal relationships make it difficult for these people to achieve their full potential socially, at work, or in school.

More common in women than in men (perhaps by a 3:1 ratio), this personality disorder is identified in as much as 2% of the general population and in 10–20% of mental health patients.

Warning: In my opinion, clinicians too often content themselves with a diagnosis of borderline personality disorder when patients have other disorders that require more urgent treatment. In the 21st century, it may still be the condition we most often overdiagnose.

Obsessive–Compulsive Personality Disorder

Patients with obsessive–compulsive personality disorder have a lifelong tendency to be rigid and perfectionistic. Insistence on a flawless product yields one that is never completed; as Voltaire wrote, "The perfect becomes the enemy of the good." Preoccupation with detail, order, adherence to rules, and insistence that things be done their way interfere with their effectiveness in work or social situations. They will try to push past failure long after most people would have judged the effort futile. High, often unreasonable standards (scrupulosity) create difficulty attaining goals or completing tasks. Work trumps relationships—their identity tends to be in their work, which they prefer to leisure or social activities. Stubborn rigidity also damages relationships with other people, whose feelings and ideas they have difficulty understanding.

Patients with obsessive–compulsive personality disorder may have trouble expressing affection; often they seem quite depressed. Though these moods may wax and wane, they can sometimes become severe enough to drive patients to treatment. Men are twice as often affected as women; perhaps 1 in 100 are affected in the general population.

Narcissistic Personality Disorder

People with narcissistic personality disorder have a lifelong pattern of grandiosity (in behavior and in fantasy), thirst for admiration, and efforts to attract the attention of others. With the conviction that they are more than usually special, even superior to others, they are self-centered individuals who commonly exaggerate their own accomplishments.

Despite a sometimes condescending attitude of entitlement, individuals with this personality disorder have fragile self-esteem and often feel unworthy. Even at times of great personal success (many are talented), they may feel fraudulent or undeserving. Motivated as they are by the desire for approval, they remain overly sensitive to what others think about them and may feel compelled to extract compliments. When criticized, they may cover their distress with a façade of icy indifference. As sensitive as they are about their own feelings, they have little apparent understanding of the feelings and needs of others and may feign empathy, just as they may lie to cover their own faults.

People with narcissistic personality disorder often fantasize about wild success and envy those who have achieved it. Relationships may be formed on the basis of who can help them achieve their goals, who will stoke their egos. Their job performance can suffer (due to interpersonal problems) or can be enhanced (due to their eternal drive for success).

This personality disorder is more common in males than in females; it is identified in less than 1% of the general population. (Note that narcissistic traits don't necessarily imply ultimate personality disorder in children and teenagers, who are normally self-centered.)

Avoidant Personality Disorder

People with avoidant personality disorder feel inadequate or personally unappealing and are socially inhibited. Judging themselves inferior, they are often hypersensitive to criticism and rejection.

Anxiety and worry about disapproval or some other calamity makes these people self-effacing and eager to please others, but it can usher in marked social isolation. They may misinterpret innocent comments as critical; often they will refuse to begin a relationship unless they are sure they will be accepted. They hang back in social situations for fear of saying something foolish, and will avoid goals (even occupations) that involve personal risk or social demands. Other than close relatives, they tend to have few intimate friends. Comfortable with routine, they may go to great lengths to stay in a rut. In an interview, as in social situations, they may feel tense and anxious; they may misinterpret even benign statements as criticism.

When they do engage in activities, they often don't seem to show much interest or enjoyment. Although many such people work and marry, they may become depressed or anxious if they lose their support systems.

Avoidant personality disorder probably occurs in just under 1% of the general population, sometimes associated with a disfiguring illness or condition; it is found about as often in men as in women. This personality disorder is not often seen by itself clinically; these patients tend to come for evaluation only when another illness appears. (Avoidant traits are common in children and don't necessarily imply later personality disorder.)

APPENDIX C

Sample Interview, Written Report, and Formulation

INTERVIEW WITH PATIENT

The patient, a man who appears to be in his late 20s, is dressed in a hospital gown over chino pants and a white shirt, buttoned to the top. He sits in a straight-backed chair, seldom gazing at the interviewer. His nose and lips are swollen and bruised, and there is a large cut under his right eye. His facial expression is immobile; he doesn't smile once throughout the interview. His words are occasionally slightly mumbled. The interviewer's voice is warm and quiet.

INTERVIEWER: *(Shakes hands with the patient.)* Good morning. My name is Dr. _____.

PATIENT: Hi.

INTERVIEWER: I want to thank you for helping us out today with this demonstration interview.

PATIENT: It's OK.

INTERVIEWER: I'll probably take notes from time to time, just to remind me of questions I might want to ask. Now, can you tell me a little bit about what sort of difficulty brought you here?

PATIENT: Um—hopelessness, despair, nowhere to go but to the heavens.

INTERVIEWER: Nowhere but to the heavens. Does that mean that you were thinking about dying?

PATIENT: Thinking?—Wanting!

INTERVIEWER: Wanting to die. Can you tell me a bit more about that?

Of course, "Tell me more about that" is the classic, open-ended request for the patient to elaborate further on what was just said.

PATIENT: Well, I'm thinking, an option is either to hurt someone or hurt myself. And I don't like hurting anyone, and so I'd rather hurt myself.

INTERVIEWER: I see.

PATIENT: And I don't want to live. You can die if you have, like, cancer, but not when you have your head so screwed up. So you have to live with that.

INTERVIEWER: Yes.

PATIENT: They don't call that terminal, they call that . . . "oh, well!"

INTERVIEWER: So did you actually make some kind of a suicide attempt?

PATIENT: Oh, yeah! The voices said, "Jump, now's the time." I took all my clothes off; I figured, "You won't be needing these." And they all stopped, all the vehicles stopped, so I ran across the street and then—that's the last thing I remember, seeing a truck in the distance going faster than everyone else. I went for it.

INTERVIEWER: So you headed right for the truck.

With several responses so far, the interviewer's contributions have largely been made to facilitate more speech on the patient's part. The principle of free speech is largely preserved.

PATIENT: Fast truck. I remember being in the ambulance, someone beating on me, telling me to wake up.

INTERVIEWER: So you were actually hit by the truck, do you think?

PATIENT: That's what they say, yeah, and by the looks of it.

INTERVIEWER: Yeah, it looks like you got beaten up a little bit. And then you remember being in the ambulance.

Notice the "Yeah" in the last speech–not at all the usual style of this interviewer, who may be unconsciously trying to make a connection by using speech similar to the patient's own. Throughout the interview, this interviewer uses words the patient can understand; there is little in the way of medical jargon that might be confusing or inhibit the formation of rapport.

PATIENT: For a split second, while they were beating on me.

INTERVIEWER: Well, how does it seem to you now? I mean, you tried to kill yourself—and here you are, not dead.

PATIENT: It seems. Well, in the hospital I thought I was dead. I was in this white room. It was like the waiting area before Heaven. I was in the waiting area; it was just some room.

INTERVIEWER: Uh-huh.

PATIENT: And now, I think, I might still be in a waiting area.

INTERVIEWER: I see.

PATIENT: You guys will help with that?

INTERVIEWER: Well, I suspect that nobody here is going to help you die.

A direct answer is better than an evasion. However, a still better response would have been on the order of the classical "I can't do that, but I can do this"–for example, "We'll do all we can to help you want to live."

PATIENT: Oh.

INTERVIEWER: Do you still want to die?

PATIENT: *(Nods.)*

INTERVIEWER: You said that you'd been feeling hopeless. How long had that been?

Note that the interviewer often picks up on the patient's own words to turn the conversation in another direction.

PATIENT: Years.

INTERVIEWER: Uh-huh. Has it been worse recently?

PATIENT: Oh, yeah. I was hopeless once in a while. It wasn't every day. Since last summer.

INTERVIEWER: Since last summer. So that's how many months now?

PATIENT: Seven.

An apparent attempt to roughly assess the patient's orientation to time and ability to calculate.

INTERVIEWER: Uh-huh. Had you been having other feelings? Like, had you felt worthless?

PATIENT: Oh, yeah.

INTERVIEWER: Do you have any idea why?

PATIENT: Well, I tried to get jobs, thinking that might work.

INTERVIEWER: Yes.

PATIENT: Can't get one.

Thus far, the interviewer has identified three areas of clinical interest to investigate: psychosis (the voices), mood disorder, and social difficulties. There may be more to come.

INTERVIEWER: Do you feel pretty much the same throughout the day, or is one time of day better for you than another?

PATIENT: Best is at night, right when I go to bed.

INTERVIEWER: So when you go to bed at night, that's better somehow. Has your sleep been pretty good?

PATIENT: Here [in the hospital] it has.

INTERVIEWER: How about normally . . . what sort of trouble do you have with your sleep?

A less careful interviewer might move on to some other topic, rather than pinning the patient down on the subject of his sleep prior to hospitalization. I wonder, though, about

using the term "normally"–just what does that mean? It might be better to specify a time frame, such as "just before you were admitted."

PATIENT: I'd wake up every hour, grinding my teeth.

INTERVIEWER: Mm-hmm. When you wake up, do you think about things?

PATIENT: Yeah.

INTERVIEWER: What sorts of things?

PATIENT: "What am I going to do?"

INTERVIEWER: Uh-huh. Do you sleep pretty soundly in the morning, then?

PATIENT: Not until recently.

INTERVIEWER: Uh-huh. Do you wake up really early, before it's time to get up, and then you don't get back to sleep at all?

Better would be the open-ended "What sort of trouble were you having?"

PATIENT: Yeah. I'm saying, "Why did I wake up so early?"

INTERVIEWER: Do you feel rested when you sleep?

PATIENT: Yeah.

INTERVIEWER: You do feel rested.

PATIENT: But I feel pretty rested when I don't sleep. It's weird; it seems I don't need sleep.

INTERVIEWER: How's your appetite?

PATIENT: Good. Here it is.

INTERVIEWER: How about before you came in?

PATIENT: Not good.

INTERVIEWER: Has your weight changed any?

PATIENT: Yeah. I lost 10 pounds. I don't know about now; I might have gained weight.

INTERVIEWER: Mm-hmm. Over what period of time did you lose 10 pounds?

Throughout this interview, you'll note that the clinician uses a lot of verbal encouragements–"uh-huh" and its variants–as a clear but minimally intrusive way to indicate that the patient's message is being received and that the information flow should continue, without directing that flow in any way. What the written record cannot show is the use of nods, smiles, eye blinks, and other nonverbal methods that encourage with no intrusion at all. To improve readability, I've cut out about half the nondirective verbal encouragements the interviewer actually does use.

PATIENT: About a week.

INTERVIEWER: So that's pretty rapid. You weren't eating much. Not interested in food?

PATIENT: Not much.

INTERVIEWER: Were you interested in other things?

PATIENT: Nope. Well, I had a girlfriend who has a kid. I was interested in him.

INTERVIEWER: You're interested in your girlfriend's child.

PATIENT: He's a nice boy. I helped him.

INTERVIEWER: And at the time you made your suicide attempt, were you maintaining your interest pretty much in that child?

PATIENT: Yeah, but she didn't want me around.

INTERVIEWER: She didn't want you. What about things like reading or watching television—was your interest good there?

PATIENT: No.

INTERVIEWER: Could you keep your mind on things?

PATIENT: Yeah, television, if I did watch it. That's about it. *(Pause)* But not for long periods.

If the interviewer moved on too quickly to the next topic, the overall impression of this patient's ability to focus his concentration would be somewhat different.

INTERVIEWER: Just for a short time? Like, about how long?

PATIENT: Half-hour.

INTERVIEWER: So you couldn't watch a full-hour show and retain it.

PATIENT: Without thinking about something.

INTERVIEWER: Would you find that when people you liked were around, that took your mind off feeling bad?

PATIENT: Yeah.

INTERVIEWER: That would help. How long would it help for?

PATIENT: Until I realized what was going on with me.

INTERVIEWER: So that would be just, like, for a few minutes it would distract you?

Objection, Your Honor–leading the witness! Much better would be "How long would it usually distract you?"

PATIENT: Yeah.

INTERVIEWER: OK. Did you feel guilty about things?

PATIENT: Yeah.

INTERVIEWER: What sorts of things?

PATIENT: That I put myself in this position. I could have avoided it by certain decisions I made. But now it's too late.

INTERVIEWER: Mm-hmm. Do you feel that you're deserving to die?

PATIENT: Yeah.

INTERVIEWER: Do you feel like you're deserving to be punished?

PATIENT: Yeah, in a way.

INTERVIEWER: Mm-hmm.

PATIENT: I know a lot of people do it, but I knew better.

INTERVIEWER: You knew better. A lot of people do . . . do what?

Again the interviewer is picking up on the patient's previous speech, this time with elaboration. It's a method of verbal encouragement that can guide the conversation without appearing to be excessively controlling.

PATIENT: Similar things to what I do.

INTERVIEWER: Uh-huh. The things that you feel guilty about. Can you tell me what some of those are?

PATIENT: Like spending money on drugs. Staying in hotel rooms instead of spending it on apartments or food.

INTERVIEWER: Mm-hmm.

PATIENT: Bills.

INTERVIEWER: Right. And what sort of drugs have you been having a problem with?

PATIENT: Heroin and cocaine.

INTERVIEWER: Has this been for quite a long time?

PATIENT: Couple of years.

INTERVIEWER: How much of a heroin habit have you had?

PATIENT: I'd say a half gram a day.

INTERVIEWER: And how much would that cost you?

PATIENT: Twenty bucks. And 20 bucks for coke.

INTERVIEWER: And also $20 for cocaine. Well, as habits go, how strong would you say that is?

PATIENT: Do I want it now?

INTERVIEWER: Yeah.

PATIENT: Strong.

This interviewer either isn't sure just how much of a habit half a gram is, or wants to give the patient an opportunity to demonstrate some expertise. In any event, asking a patient for an explanation is a good way to ensure that you have the right information. It also helps promote rapport.

INTERVIEWER: So you feel a pretty strong craving right now.

PATIENT: Not really that strong a craving; just probably if I had a lot of money and a place to go, I would probably do it.

INTERVIEWER: You would go out and use drugs again.

PATIENT: 'Cause they make me feel safe.

INTERVIEWER: Back before you were using drugs, how was your mood then?

With two serious problems to consider, the interviewer is trying to learn which one started first. The important reason: to differentiate between a primary mood disorder and one that is secondary to drug use, with their differing treatment implications.

PATIENT: It would depend where I was at, but . . . there was always something missing.

INTERVIEWER: Always something missing, even before you were using drugs.

PATIENT: Yeah. And back in school, I never fit in, really. I mean, I had friends, but I didn't fit in.

Another area of clinical interest rears its head: the possibility of personality disorder.

INTERVIEWER: Mm-hmm.

PATIENT: Uncomfortable.

INTERVIEWER: You felt uncomfortable, even with friends. Can you talk about that a little bit more, about that feeling of discomfort?

Even this far into the interview, the interviewer extends an invitation to expand on these feelings. Open-ended probes are an excellent way to develop information about emotions.

PATIENT: Like, you don't want to say the wrong thing or get made fun of. You don't want to do anything that will get you made fun of. So really, you just keep quiet, keep to yourself. And then nothing does happen. You don't get more friends.

INTERVIEWER: So you were always very afraid of making a mistake, of seeming out of place. And that's at least partly because you *felt* out of place. Has that been true throughout your adult life?

Ordinarily, I recommend against long interviewer speeches. After all, the more an interviewer talks, the less time the patient has to talk. However, occasional summary statements, such as the one just above, can ensure that the interviewer has understood and can help connect with the patient.

PATIENT: *(Nods.)*

INTERVIEWER: What about when you were a kid?

PATIENT: That's the only time when I wasn't afraid, before my parents got divorced. I remember the first day we lived here, my parents said, "There's a kid out there your age—go play with him." I ran out there, pushed him on his tricycle. We became best friends.

INTERVIEWER: And that was when you were how old?

PATIENT: Five.

INTERVIEWER: And did that [friendship] last clear up until your parents got divorced?

PATIENT: *(Nods.)*

INTERVIEWER: And how old were you then?

PATIENT: Parents got divorced when I was about 7—6, 7.

INTERVIEWER: Did you live with your mom or with your dad then?

PATIENT: My mom, in California, so I missed some school. My other brothers lived with my dad. 'Cause they were going to school.

INTERVIEWER: And was it when you were 7 or so that you started to feel out of place?

PATIENT: I think so. I mean, right from the start, I felt awkward in certain situations. I gradually got it back, then it all went to heck. Then I switched schools and then I got it back again. And then I went to a middle school and lost it all. And never got it back.

INTERVIEWER: You lost it all—what does that mean?

PATIENT: It means all my friends were in a different area than I was, and I had to make all new friends, and I never did.

INTERVIEWER: So you never really got back to where you were.

PATIENT: Yeah, and I just kept it there.

INTERVIEWER: Back then, when you were, say, a teenager, did you feel depressed then?

PATIENT: Mm-hmm.

INTERVIEWER: Was it as depressed as you're feeling now?

PATIENT: No, I thought of suicide, but I'd never do it.

INTERVIEWER: And when was the first time you made a suicide attempt?

PATIENT: Two years ago.

INTERVIEWER: Uh-huh. Was that after you started to use drugs?

This interviewer puts quite a lot of effort into determining the sequence of symptoms–what happened first, followed by what else? This information will prove important in diagnosis and in determining what treatment might help.

PATIENT: *(Nods.)*

INTERVIEWER: And what did you do to yourself then?

PATIENT: I tried to shoot the most heroin I ever did.

INTERVIEWER: You tried to overdose on heroin.

PATIENT: Yeah, and I took some prescription pills.

INTERVIEWER: And obviously that didn't work.

PATIENT: Right.

INTERVIEWER: Were you hospitalized then?

PATIENT: Yeah, I woke up 3 days later.

INTERVIEWER: That's quite a long time.

PATIENT: That was the closest.

INTERVIEWER: And have you made any suicide attempts between then and this one?

Have you noticed that the interviewer starts many questions with the word "And"? We all have verbal tics, which can be annoying or helpful to one degree or another. I would recommend that you analyze your own to see which should be expunged. In this case, however, the repeated conjunction may actually serve to help tie the interview together while moving it forward.

PATIENT: Yeah, I took a bunch of over-the-counter sleeping pills. Those things just made my heart go crazy, so I took myself to the emergency [room].

INTERVIEWER: Mm-hmm.

PATIENT: And then I felt myself passing out when I got there. They charcoaled me, and that was . . . *(Long pause)*

INTERVIEWER: Well, now, you said that you had been hearing voices. Can you tell me about that?

PATIENT: My head's thinking one thing, and then this voice will sound, like, outside, inside my head, I don't know: "It's OK. Just do it."

INTERVIEWER: By that is meant . . .

PATIENT: Whatever I'm thinking.

INTERVIEWER: Whatever you're thinking. So this voice kind of encourages you.

PATIENT: *(Nods.)*

INTERVIEWER: Does it ever say anything different from that?

PATIENT: It tells me not to do stuff.

INTERVIEWER: Like what?

PATIENT: Like "It's a bad idea right now. Don't do it."

INTERVIEWER: Mm-hmm.

PATIENT: I've always had it.

INTERVIEWER: You've always had this voice. Dating back to when?

PATIENT: When I was a kid. It kept me out of trouble, a lot of times.

INTERVIEWER: I see. Do you think that this voice is an actual person or thing out there somewhere? Or could it be your own conscience or your own thoughts?

Note the forced choice. An open-ended question might have worked better here–for example, "Or could there be some other explanation?"

PATIENT: I used to think it was my conscience until recently, when it got so strong I can almost see it. And that's when I started thinking it was something else.

INTERVIEWER: Mm-hmm.

PATIENT: My brother died. I swear that has something to do with it.

INTERVIEWER: I didn't understand that.

PATIENT: My brother got murdered. And that had something to do with me not dying.

INTERVIEWER: So you're thinking that—

PATIENT: At the time I was trying to do the heroin overdose, same day I got out of the hospital, my grandfather died.

INTERVIEWER: Wow!

Shorthand for "That's a really heavy load for one person." This sort of response tells the patient that the clinician understands and cares; it is a premier example of one-word rapport building.

PATIENT: It was, like, they had to do a switch. Me for him. It was already safe.

INTERVIEWER: So you think that in some way, your grandfather died so you could live?

PATIENT: *(Nods.)*

INTERVIEWER: That's a pretty big responsibility. How does that make you feel?

PATIENT: Well, he was really sick. And that's the kind of guy he is, so I'm not surprised.

INTERVIEWER: What did he die of?

PATIENT: Old age.

INTERVIEWER: And you said that your brother died—he got murdered.

Good for this interviewer, who remembered to ask about the murdered brother! This may have been facilitated by the note taking mentioned at the outset of the interview.

PATIENT: He was stabbed. And he got only about 2 years.

INTERVIEWER: The person who stabbed him only got 2 years in prison for that. What were the circumstances?

PATIENT: He'd just got out of prison, my brother, and he didn't know where to go, and he was sleeping in the park with bums. And they were cooking, and he went to borrow a bike that wasn't his, to buy beer, and the dude whose bike it was just flipped out—said "Get off my bike," and went after him with a knife.

INTERVIEWER: I see. So your brother had been in prison, for what?

PATIENT: For burglary.

INTERVIEWER: And had he been in a lot of trouble much of his life?

PATIENT: Not really, just alcohol.

INTERVIEWER: Oh, he drank. And was that why he did the burglary—he was intoxicated at the time?

PATIENT: Yeah.

INTERVIEWER: And has anybody else in your family had any drug or alcohol problems?

PATIENT: Yeah, my brother.

INTERVIEWER: Another brother?

PATIENT: Yeah, and then my aunt and uncles.

INTERVIEWER: So you had some aunts and uncles, on your dad's side or—

PATIENT: Mom's side, and then my stepdad.

INTERVIEWER: Was your mother a drinker or a drug user?

PATIENT: Yeah.

INTERVIEWER: Tell me about her.

PATIENT: She would drink and smoke pot.

INTERVIEWER: And is she still alive now?

PATIENT: *(Nods.)*

INTERVIEWER: Is she still drinking?

PATIENT: No.

INTERVIEWER: She got straightened out. How did that happen?

PATIENT: She quit.

INTERVIEWER: Does that make you feel that there's some kind of hope for you?

PATIENT: I quit before. I've had 7 months clean.

INTERVIEWER: Really? That's terrific! When was that?

The compliment is hardly necessary, but in context it seems heartfelt, and perhaps it does help to cement whatever feelings the patient may be forming for the interviewer.

PATIENT: Last year.

INTERVIEWER: And then you just slipped back into it.

PATIENT: I just felt like shit still.

INTERVIEWER: You mean, even though you were clean and sober, you still felt very depressed.

PATIENT: Uh-huh. Hopeless. And I had money.

INTERVIEWER: Were you working at that time?

PATIENT: No, but I had $6,000 in the bank.

INTERVIEWER: Really! Wow. And that didn't help you to feel any better.

PATIENT: Nope.

INTERVIEWER: Even though you were not using, not drinking, you still felt terribly depressed.

PATIENT: *(Nods.)*

INTERVIEWER: And were you thinking about killing yourself then?

PATIENT: *(Nods.)*

INTERVIEWER: Do you think you felt about as bad then as you do now?

PATIENT: *(Nods.)* Yup.

INTERVIEWER: Well, I was asking about your relatives. I heard about your brothers and your mom. What about your dad—was he a drinker or a drug user?

PATIENT: My stepdad.

INTERVIEWER: What about your biological father?

PATIENT: He did that stuff, but he quit. But when I was growing up, he was a drinker.

INTERVIEWER: I see. What kind of work did he do?

PATIENT: He was a sales manager.

INTERVIEWER: And do you have any kind of a relationship with him now?

PATIENT: Now, more so than I did. I didn't for a while.

INTERVIEWER: Mm-hmm. And what about your mom—do you see her?

PATIENT: *(Nods.)*

INTERVIEWER: How do you and she get along?

PATIENT: Pretty good, for the most part.

INTERVIEWER: You know your brother died at one point, and your grandfather died, and I'm sure that you felt bad when those events happened. Can you compare how you feel now, with your depression, to the way you felt when they died?

PATIENT: When my brother died, I felt relief for him. He was lucky; he didn't have to go through that crap any more. Same with my grandpa, 'cause he was in pain. So my depression [compared to] that—I wish I could be with them.

INTERVIEWER: So the way you feel now, it's quite different from how you felt when they died. Is that correct?

An important summary statement–to try to characterize the type and degree of depression now, as compared with how people feel when a loved one dies. This sort of information can be used to help sort out the type of mood disorder when the interviewer considers the differential diagnosis.

PATIENT: Yeah.

INTERVIEWER: And do you still feel now that you wish you were dead?

PATIENT: Yes.

INTERVIEWER: You said that you hoped that somebody here would help you to die. Does that seem like a realistic hope to you?

PATIENT: I don't see why not; they do it for people with cancer. My brain has cancer.

INTERVIEWER: Your brain has cancer—what do you mean by that?

PATIENT: Cancerous thoughts.

INTERVIEWER: Cancerous thoughts. Well, suppose that with medication or some other treatment, your brain could get over these cancerous thoughts?

PATIENT: Yeah, well, that would be something else.

INTERVIEWER: That would be something different.

PATIENT: Kind of works with heroin. The thing with heroin, it just shuts the cancerous thoughts down. But it doesn't make you feel better. I don't want to hang out with anyone. I just like to sit in a room and watch TV, and the cancerous thoughts be shut down. And that's why I do that.

INTERVIEWER: Does it seem to you that when you use heroin, it's to shut down some of these really bad, negative thoughts that you have?

PATIENT: Exactly.

INTERVIEWER: You mentioned that you heard these voices. Have you ever had any other experiences that most people don't have?

Good use of transition–picking up on the patient's own words and using that as a bridge to other questions about mental phenomena.

PATIENT: Uh, no.

INTERVIEWER: Do you see visions, for instance?

PATIENT: Yeah.

INTERVIEWER: Tell me about that.

PATIENT: I see visions of me hanging.

INTERVIEWER: Hanging, like by a rope, you mean?

PATIENT: See visions of me smashing my car into a brick wall. I see visions of me jumping off the train platform, right into the train.

INTERVIEWER: Are those visions something that you can actually see, just the way you see me now? Or is it more like something that's played on your mental mind's screen?

PATIENT: No, I see it.

INTERVIEWER: You can actually see it. You see it as clearly as you see me?

PATIENT: Yeah.

INTERVIEWER: And have you ever had the feeling or thoughts that people were plotting against you in some way or another, trying to harm you?

PATIENT: No.

INTERVIEWER: Spy on you?

PATIENT: Spy on me, yeah.

INTERVIEWER: Tell me about that.

PATIENT: Cops do these things. Try to stop me.

INTERVIEWER: Uh-huh. So you thought that may be the police might be trying to stop you from harming yourself.

PATIENT: Yeah. There's cameras everywhere.

INTERVIEWER: On this ward there are cameras, that's true. What about outside? Do you feel there are cameras everywhere there?

PATIENT: Pretty much. You go to malls, there will be. There's cameras on lights, stoplights.

INTERVIEWER: Has anybody in your family ever had any other mental illnesses besides using drugs or alcohol?

Oops. This would be an excellent point to ask whether the cameras are focusing just on him, or whether they are intended for use on everyone. The latter response would of course evoke far less concern.

PATIENT: *(Shakes head.)*

INTERVIEWER: Depression.

PATIENT: Yeah, my stepdad.

INTERVIEWER: Your stepdad.

PATIENT: He did drugs and he quit, and he's been clean for 6 or 7 years. The other day, he had to go home because he's so depressed.

INTERVIEWER: Anybody besides your stepdad?

PATIENT: No.

INTERVIEWER: Anybody in the family with schizophrenia? . . . Any kind of psychosis or craziness? . . . Anybody else who's ever tried to kill himself?

The interviewer pauses after each question to allow the patient time to think about his answer.

PATIENT: *(Shakes his head "no" to each of the questions above.)*

INTERVIEWER: Let's see, you had two brothers. Any other brothers or sisters?

PATIENT: No.

INTERVIEWER: Are you oldest or—

PATIENT: Youngest.

INTERVIEWER: You're the youngest. How old are you now?

PATIENT: Thirty-one.

INTERVIEWER: Uh-huh. And you mentioned your experiences when you were growing up. How far did you go in school?

PATIENT: All the way . . . high school, graduated. Went to college for a little bit.

INTERVIEWER: And what kind of work have you done?

PATIENT: I've done carpet; I worked in a car wash; delivering pizza. I've worked in warehouses.

INTERVIEWER: Do you like working?

PATIENT: Yeah.

INTERVIEWER: You get a good feeling out of that.

PATIENT: Yeah.

INTERVIEWER: What's the longest job you've held?

PATIENT: Five years.

INTERVIEWER: That's pretty good. What was that?

Another compliment. A good rule is this: Never say anything that is complimentary unless you truly mean it. It sounds as though this interviewer does.

PATIENT: Delivering pizza.

INTERVIEWER: And once you leave here, do you think you might try to get another job?

PATIENT: I've been trying, but they don't call me back. That's why I get hopeless.

INTERVIEWER: Yeah. Your brother was in prison at one time. Have you ever had troubles like that?

The interviewer uses previous information as a bridge to a topic that could be sensitive.

PATIENT: Never.

INTERVIEWER: And you mentioned your girlfriend. Have you ever been married?

PATIENT: No.

INTERVIEWER: Have you had quite a few girlfriends?

PATIENT: Yes.

INTERVIEWER: And has your relationship with women been pretty satisfactory ordinarily?

PATIENT: Yeah.

INTERVIEWER: Sexual satisfaction?

PATIENT: OK.

INTERVIEWER: How about when you're really depressed? Is your interest in sex different when you're really depressed?

Note that this interviewer has delayed for a long time the question about libido when depressed–until it flows more naturally into the conversation, and until the patient is maximally used to the interview process.

PATIENT: Don't do it.

INTERVIEWER: You just don't do it. Not interested? How's your physical health been?

PATIENT: Good.

INTERVIEWER: Have you had any difficulty that has caused you to have an operation?

PATIENT: My back hurts.

But did he ever have an operation? In context, it seems reasonable to assume that he did not, but one goal of interviewing is accuracy.

INTERVIEWER: Have you ever been unconscious, other than when you were hit by the truck?

PATIENT: *(Shakes head.)*

INTERVIEWER: Have you had other hospitalizations, besides psychiatric?

PATIENT: Just when I was a kid. I fell on my head, from about 8 feet high.

INTERVIEWER: Wow!

PATIENT: I was playing hide-and-seek, and I landed on my head. Cracked both wrists. Got a concussion.

INTERVIEWER: And you were out for how long then?

PATIENT: A split second. But I was dizzy all day long.

INTERVIEWER: I see. Did you recover from that fairly quickly then?

PATIENT: Yeah. I slept that night in the hospital.

INTERVIEWER: Now, I know you've had difficulty with depression for quite some time. Have you had antidepressant treatment of any kind?

PATIENT: Just pills.

INTERVIEWER: What kind of pills have you had?

PATIENT: Lexapro, Wellbutrin, and Depakote.

INTERVIEWER: And did those seem to make any difference?

PATIENT: Unh-unh.

INTERVIEWER: How long did you take each one of them?

PATIENT: Four months for Lexapro, a month for the Wellbutrin and Depakote.

INTERVIEWER: And why did you stop taking them?

PATIENT: Lexapro was making me tired and upset my stomach. Same with the Depakote and Wellbutrin.

INTERVIEWER: Do you know how much you were taking of each of those?

PATIENT: No.

INTERVIEWER: Was it several pills a day of each?

PATIENT: Yeah. Four Depakotes, and one or two Wellbutrin.

INTERVIEWER: And the Lexapro?

PATIENT: I think it was two.

To try to pin down the adequacy of previous treatment, the interviewer has pursued this information like a terrier hunting a rat.

INTERVIEWER: And have you had any courses of psychotherapy? . . . Group therapy? . . . Cognitive-behavioral therapy?

PATIENT: *(To each in turn)* No.

INTERVIEWER: Nothing of that sort. Now, some people who have depression have the opposite feeling at times, too—where they feel ecstatic or too happy, on top of the world. Has that ever happened to you?

PATIENT: Yeah.

INTERVIEWER: Can you tell me about that?

PATIENT: Like the other day, I had a ticket for not wearing my seat belt. I took a class for 20 bucks—it was a $200 ticket—and they voided the ticket.

INTERVIEWER: That made you feel pretty good.

PATIENT: Yeah. Even though I had nothing in my wallet, [nothing] to eat, and barely any gas.

INTERVIEWER: I see. How long did that up feeling last?

PATIENT: Huh! Five minutes.

INTERVIEWER: Have you ever had up feelings that lasted for days at a time?

PATIENT: No.

INTERVIEWER: Now, are there other important experiences that you've had that you haven't talked about so far?

This is a fishing expedition, designed to provide an opportunity to discuss anything else that might be on the patient's mind. This time it turns up negative, but it's a good idea to cast such a line at least once during every initial interview.

PATIENT: No.

INTERVIEWER: Have you ever had the experience of having thoughts that seem pointless or silly to you, that you'd go back to over and over again?

PATIENT No.

INTERVIEWER: Do you have any fears or phobias?

PATIENT: Yeah.

INTERVIEWER: Like . . .

PATIENT: Fear of speaking in public, fear of drowning, fear of burning to death, fear of failure, fear of being laughed at.

INTERVIEWER: Do these fears cause you to change your way of life in any way?

PATIENT: Yeah, I avoid it.

INTERVIEWER: So what sorts of things do you avoid?

PATIENT: I avoid meeting new people. I avoid anything that can injure me.

INTERVIEWER: If you have to speak in public, are you able to do it, but it's just uncomfortable for you, or do you just not do it at all?

PATIENT: Well, going to school, we never had to do it, in college. But I would have just done it.

INTERVIEWER: So you'd have done it, but you wouldn't have been happy about it.

PATIENT: Or I'd have been bad at it.

INTERVIEWER: Would you ever get panic attacks—where you would feel something awful was about to happen to you, and your heart would beat really fast?

PATIENT: I get those all the time.

INTERVIEWER: Do you get them even now?

PATIENT: Bad. I hate that.

INTERVIEWER: What sorts of thing set them off?

PATIENT: Anything. I can be playing basketball; next thing I know, I feel one coming on. My balls get all cold, weird feelings. I know what it is; I just try to let it go. Gets me light-headed and [makes me] feel I've got to puke.

INTERVIEWER: How often do those experiences happen?

PATIENT: Depends. Sometimes when it happens, it's like four times, five times a day. Sometimes they don't happen for a month.

INTERVIEWER: Have you ever talked to a doctor about it?

PATIENT: He said I had an anxiety attack. Gave me Xanax.

INTERVIEWER: Did that seem to help?

PATIENT: Yeah.

INTERVIEWER: Of course, there are problems with Xanax, too. People can get kind of used to taking it, and they may want to take it.

This response borders on intervention: The clinician is venturing an opinion (albeit tentative) as to the dangers of certain medications. However, there is probably no harm in the context of a patient who has had considerable experience with substance misuse, and who has already made several suicide attempts.

PATIENT: It made me tired, though. They'd give me a pill and I'd break it up in fourths.

INTERVIEWER: Are you much of a worrier?

Actually, a comment or bridge would be welcome here–something to indicate that the interviewer understands the importance of the patient's not abusing Xanax. (For that matter, it wouldn't be amiss to ask a question to make sure the patient <u>hasn't</u> misused Xanax.) In any event, the interviewer might say something like "I think I understand about the Xanax. Let's move on to something else"–and then ask about worries.

PATIENT: Yeah, I worry.

INTERVIEWER: What do you worry about?

PATIENT: Anything . . . what's going to happen next . . . where I'm going to go from here . . . how can I control this . . . anything that's not in my control, I worry.

INTERVIEWER: *(With an "Uh-huh" for each of the worries mentioned above)* Have you sought help from organizations like AA or NA for drug use?

PATIENT: Yeah.

INTERVIEWER: And what sort of help has that been?

PATIENT: AA—that's where I got my 7 months clean. I stopped going because there's a lot of new people in there. They were talking about how much drugs they did, and I was like, "I don't want to hear that."

INTERVIEWER: It was a downer for you?

PATIENT: Yeah, it just makes me want to do drugs.

INTERVIEWER: But then you got back into doing drugs.

PATIENT: Yeah.

INTERVIEWER: I was curious about something you said earlier today. You weren't working, but you had $6,000 in the bank. I'm wondering how that could be.

PATIENT: I got in a car accident. The settlement was $6,000.

INTERVIEWER: I see. And did you spend that fairly quickly, then?

PATIENT: Couple of months.

INTERVIEWER: On drugs?

PATIENT: Drugs and hotel rooms, 'cause I had nowhere to live.

INTERVIEWER: Well, good. I think I have a pretty good understanding of what's happened with you. Now I'd like to change directions and ask you a couple of quiz questions, if I could. What is the date today?

This transition is an explicit notice that the interviewer has the needed information and wants to move on.

PATIENT: (*States date, month, and year correctly.*)

INTERVIEWER: And where are we right now?

PATIENT: (*Answers correctly.*)

INTERVIEWER: Let's see, did I tell you my name?

PATIENT: Dr. _____.

All interview tests of memory are only approximations, and this one–just the name of the interviewer–is pretty rough. But in conjunction with the patient's evident clarity of thought during the previous 40 minutes or so of the interview, the interviewer apparently feels justified in not pursuing the issue of memory in greater detail.

INTERVIEWER: Good. Can you tell me who the president is?

PATIENT: *(With more prompting, names several previous presidents in correct order.)*

INTERVIEWER: I know you've been asked to do things like subtracting sevens from 100. Would you mind doing that now?

PATIENT: Ninety-three.

INTERVIEWER: OK, keep subtracting sevens until you get below 60.

PATIENT: OK, 93, 86, 79, 72, 67 . . . I screwed up already.

INTERVIEWER: (*After a long pause while the patient struggles*) Well, you did great, actually.

PATIENT: Did I?

INTERVIEWER: You got farther than most people do.

PATIENT: I got them right?

The patient shows a touching eagerness for reassurance that he has performed well. It suggests the degree of his dependency. It is fair to give reassurance whenever it is merited, but not when it is obviously in opposition to the facts.

INTERVIEWER: All but the last one. And that finishes the questions I wanted to ask you today. Thank you very much for your time.

While forming and maintaining a good degree of rapport, this interviewer has obtained a great deal of material pertinent to the diagnosis and treatment of this patient. In 45 minutes, information has been obtained for every one of the eight areas of clinical interest. In addition, we have learned a fair amount (though not nearly enough) about this patient's personal and social background.

All interviews are flawed, however, and this one is no exception. Offhand, I can list half a dozen points that are either covered inadequately or not touched upon at all. How many can you find?

WRITTEN REPORT

Identifying data: This is a repeat psychiatric hospitalization for Marco Carlin, a 30-year-old single white man.

Chief complaint: "Hopelessness, despair, nowhere to go but to the heavens."

Informants: The patient alone.

History of the present illness: Mr. Carlin was admitted to the hospital following a suicide attempt in which a truck hit him while he was running through heavy traffic. He had been experiencing severe depression, characterized by feelings of hopelessness and worthlessness, for about 7 months, building on a longer history of depression that goes back many years. Prior to admission he suffered from insomnia (interval and terminal waking) and poor appetite, with a 10-pound weight loss in 1 week. However, since admission his sleep and appetite have improved. During this 7-month period of severe depression, he maintained interest in television and in his girlfriend's child, though his libido has been markedly reduced. His concentration has been somewhat diminished; people he likes distract him only briefly. He admits to guilt feelings and believes he deserves to be punished and to die. He appears to feel worse now than when he experienced the deaths of his brother and his grandfather; for the latter, death was a release. Other than a few minutes' response to a fortunate event, he denies periods of elation.

Past treatment for depression has included Lexapro (4 months on 2 tablets/day), Wellbutrin (1 month on 1 or 2 tablets), and Depakote (1 month on 4 tablets). He has never had cognitive-behavioral therapy, group therapy, or other psychotherapy.

Some of Mr. Carlin's guilt feelings center on his drug use, which has persisted for at least the past 2 years. Spending about $20 a day on heroin and $20 for cocaine, he feels he has had a serious drug use problem. He craves drugs right now and feels that he would use drugs again. Heroin shuts down his unacceptable thoughts. He states that he has felt severely depressed even when he is not using drugs or drinking.

Yet another area of concern is auditory hallucinations. He claims that for years ("I've always had it") he has heard a voice that will say things like "Just do it" and "It's a bad idea right now, don't do it." He says that this voice often helped him when he was a child. He used to consider it the voice of his conscience, but recently it has become so strong that he can "almost see it."

Personal and social history: Even as a child, Mr. Carlin felt that he did not fit in. He felt awkward, repeatedly changing schools and having to make new friends; as a teenager, he felt depressed, though not suicidal. His parents were divorced when he was about 7, after which he lived with his mother in California. His two older brothers lived with his father. He considers that he has a reasonably good relationship with his natural father and with his mother. He graduated from high school and briefly attended college. He has held a variety of jobs, including installing carpet, working in a car wash, and (for 5 years) delivering pizza. He has been out of work lately, however, and has been unsuccessful at finding another job. He has never married, but has had girlfriends. When not depressed, he has no difficulties with sexual satisfaction.

His family history includes numerous relatives who have misused substances, including his biological father, a sales manager who drank earlier in his life. A brother was in prison.

Mr. Carlin's physical health has been good overall. At age 8, the patient struck his head in a fall and was hospitalized overnight for concussion. He complains of back pain, but has had no operations; he takes no medications other than for his mental condition.

Mental status exam: Mr. Carlin still wishes that he were dead and that someone in the hospital would help him die to relieve him of his "cancerous thoughts." He believes this is a reasonable expectation. He has seen clear visual hallucinations of himself hanging by a rope, smashing his car into a brick wall, or jumping off a train platform. Although he denies persecutory ideas, he admits to some feelings that the police may be spying on him—the evidence is that there are cameras everywhere. He is oriented for person, place, and time; his fund of knowledge (presidents) is good; and his remote memory and retention/recall are unimpaired. His concentration is reasonably good; he subtracted serial sevens with one error.

Although he did not bring up these issues spontaneously, he admits to some fears (drowning, failure, burning to death, speaking in public, being laughed at). As a result, he says that he avoids people and situations that could injure him, but he admits that if he were called on to speak to an audience, he'd probably go ahead and do it. He denies obsessional ideas, but admits to panic attacks.

Impression

Diagnosis deferred

1. Mood disorder
   Depression secondary to head trauma
   Substance-induced mood disorder with depressive features

Major depressive disorder, recurrent, possibly with dysthymia
Bipolar I disorder
Bipolar II disorder

2. Substance misuse
   Cocaine use disorder, moderate
   Heroin use disorder, moderate
3. Possible anxiety disorder
   Social anxiety disorder
   Generalized anxiety disorder
   Panic disorder
   Agoraphobia
4. Possible psychosis
   Substance-induced psychotic disorder
   Major depressive disorder, severe, with psychotic features
   Schizophrenia
5. Possible unspecified personality disorder, with avoidant and schizoid traits
   Physical diagnoses: Recently hit by truck
   Psychosocial problems: Currently unemployed and homeless
   Global Assessment of Functioning:
   15 (current)
   70 (highest past year)

FORMULATION

Summary

This 30-year-old single white man was admitted to the hospital following his attempt at suicide by being hit on the highway by a moving truck. He has had depression of varying degrees dating back to about age 7; his depression has been complicated in recent years by the use of cocaine and heroin. He has been treated with several medications, largely to no avail. He has recently been unemployed and is currently homeless.

Differential Diagnosis

Depression. Major depression is supported by the presence of numerous criteria and a history of repeated suicide attempts. Mr. Carlin states that his depression antedates his use of drugs and persists even when he is not using drugs. The long-standing depressive symptoms argue for coexisting dysthymia.

Psychosis. Mr. Carlin does not have sufficient criterion A symptoms for a DSM-5 diagnosis of schizophrenia, and there is something less than compelling about his auditory hallucinations. His symptoms seem insufficiently mood-congruent for major depression with psychosis. The amount of recent substance use seems insufficient for substance-induced psychotic disorder. Nonetheless, he should be observed carefully for further emerging symptoms of psychosis.

Substance misuse. Although the extent of his substance use is unclear from this interview, it almost doesn't matter. It is obvious that use of cocaine and heroin have interfered with his life and may underlie his current depression.

Anxiety disorder. The patient has admitted to symptoms of several different anxiety disorders. There is insufficient information to support any firm diagnosis; indeed, his responses to questions suggest that he may have been overly compliant with the interview process.

Personality disorder. Some sort of personality diagnosis is supported by this patient's possible overcompliance with interview questions and long history of drug use. Diagnosis deferred for now, in light of the major diagnostic possibilities above.

Best Diagnosis

The most pressing diagnosis to address at present is major depressive disorder, along with misuse of cocaine and heroin.

Contributing Factors

Family history (father, brother) is strongly implicated in Mr. Carlin's substance misuse. Divorce of parents when the patient was young may have contributed to mood disorder. Substance use and depression may exacerbate one another.

Further Information Needed

In addition to prior medical records and the impressions of other clinicians, interviews with parents may help to disentangle the threads of Mr. Carlin's depression and substance use, as well as to resolve the questions concerning possible anxiety disorder(s) and psychosis. Subsequent interviews should reveal additional details not covered already, including the means of his current support, religious history, and military service.

Treatment Plan

Further trials on antidepressant medication
Psychotherapy (perhaps cognitive-behavioral therapy) directed at feelings of depression
Twelve-Step program for substance misuse
Referral for assistance with housing and employment

Prognosis

If the diagnosis of major depression is accurate and the patient responds to medication and cognitive-behavioral therapy, it might provide a platform from which to succeed in managing his substance use. On the other hand, if his substance use cannot be brought under control, management of his depression could prove very difficult. The prognosis is complicated by the possibility of a personality disorder.

APPENDIX D

A Semistructured Interview

For decades, clinicians have used structured and semistructured interviews to gather health care data. These instruments are more effective than traditional free-wheeling interviews at producing accurate principal diagnoses and at uncovering secondary diagnoses. For example, one study found that the Structured Clinical Interview for DSM (SCID) identified five times more clinical diagnoses than were documented in the patients' charts. Also to the good, structured instruments can reject unwarranted clinical diagnoses; a study of homeless patients found that structured interviews identified fewer cases of antisocial personality disorder than did traditional clinical methods.

I've written this appendix not to replace the clinical interview of an adult, but to help you cover the ground necessary for the most complete diagnosis possible. Although the questions will provide the material for making diagnoses, they won't score themselves. For example, you'll have to evaluate whether your depressed patient has major depressive disorder, a bipolar depressive episode, or dysthymia—and, if it is one of the first two, whether a specifier (such as *with anxious distress*, *with melancholic features*, or *with seasonal pattern*) is in order. At many points, you will have to elicit details; in an interview structured for a technician to administer, that work would be done for you. This guide is intended for mental health care professionals who already have a grounding in mental disorders.

Screening questions (in **boldface**) appear twice: just below, and again at the beginning of each diagnostic set. (There is some evidence that asking all the stem questions *first* helps discourage a tendency to say "no" once the person discovers that positive answers lead to further questioning.) If you get negative answers to a set of screens, you can skip the follow-up questions and move on.

The last two sections contain no screens, but don't pass them by. They will remind you of the tremendous breadth of information you need about your patient's background, personality, feelings, and general behavior.

By the way, some of the questions appear in sections that don't correspond exactly to recent diagnostic manual revisions. For example, I've grouped gambling with other impulse-control disorders, not with substance use. That's because the diagnostic manuals try to place disorders in scientifically related groups that don't always follow the symptoms we see clinically. For ease of administration, I've usually stuck with the more traditional groupings.

ALL SCREENS

A1. Was there ever a time when you felt unusually down, depressed, or sad most of the day?

A2. Was there ever a period when you felt that most of the time you didn't enjoy your usual activities or take pleasure from them?

B1. Have you ever had a time when you felt the opposite of depressed—you felt unreasonably happy, euphoric, "too happy"?

B2. Did you ever have a time when you (or others) noticed that you were unusually cross, irritable, or cranky?

B3. Have you had periods when you were much more active than is normal for you?

C1. Have you ever have an attack or spell when you suddenly felt anxious, fearful, or extremely uneasy?

C2. Have you ever had a sudden attack or spell when you felt faint, you felt you couldn't breathe, or your heart seemed to race?

D1. Have you had fears or phobias related to anything? Examples: animals (such as spiders, dogs, snakes); blood, needles, or injections; heights; airplane travel; being closed in; thunderstorms; blushing; eating in public; speaking, singing, or playing a musical instrument before an audience.

D2. Have you had anxiety about being in a place or situation (such as a store or the movies)—a place that you'd have trouble escaping from, or where there might be no help available if you had a panic attack?

E1. Have you ever had ideas or thoughts that keep coming back to you—thoughts that you try to resist but cannot?

E2. Do you ever experience physical behaviors that you feel you have to perform over and over, such as handwashing, checking the stove, or counting things?

F1. Have you ever had a traumatic, stressful experience that you found you kept on reliving or having to avoid?

G1. Do you worry a great deal of the time?

G2. What do you worry about?

H1. Have you ever had unusual experiences such as seeing visions or hearing voices that other people couldn't see or hear?

H2. Do you ever taste things or smell things that other people cannot, or feel things on your skin or in your body that other people don't?

J1. Have you ever felt that people were spying on you, talking behind your back, or working against you in some other way?

J2. Have you ever felt you had some sort of a special mission in life—perhaps a divine purpose or calling?

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J3. Have you had some other seemingly strange experience you couldn't explain or account for?

K1. Have you ever used alcohol or street drugs?

K2. Have you ever taken prescription or over-the-counter medication in a way that was different from the recommendation or prescription?

K3. Have you ever felt you drank or used drugs to excess?

K4. Have other people ever expressed concern about your drinking or drug use?

L1. How has your memory been? I'd like to test it, if that's OK.

L2. Have you ever had experiences or periods in your life that you couldn't remember later?

L3. Did you ever find yourself in a strange location and couldn't remember how you got there?

M1. Has your general health always been good?

M2. Have you had much medical attention for different conditions?

N1. Have you ever felt fat when people said you were too thin?

N2. Did you ever make yourself throw up because you felt so full?

N3. Do you ever go on eating binges, when you rapidly eat far more than normal?

P1. Have you ever felt or feared that there was something terribly wrong with you physically—some serious condition that doctors couldn't identify?

Q1. Have you ever felt that there was something about your body or your appearance that wasn't right—something that other people didn't seem to recognize?

R1. Do you easily become angry?

S1. Do you ever behave impulsively?

S2. Do you ever do things like pull out strands of your hair . . . or become destructively aggressive . . . or steal from stores . . . or set fires? [Pause for response between symptoms.]

T1. Do you gamble?

U1. Has any blood relative—by which I mean a parent, brother, sister, grandparent, child, aunt, uncle, cousin, niece, or nephew—ever had symptoms like yours?

U2. Has any of these relatives had any mental illness, including depression . . . mania . . . psychosis . . . schizophrenia . . . nervousness . . . severe anxiety . . . mental hospitalization . . . suicide or suicide attempt . . . alcoholism or other substance misuse . . . or a history of criminal behavior? [Pause for response between illnesses.]

MOOD DISORDERS

A1. Was there ever a time when you felt unusually down, depressed, or sad most of the day?

A2. Was there ever a period when you felt that most of the time you didn't enjoy your usual activities or take pleasure from them?

If "yes" to either:

Did you feel that way most days?

How long did these periods last?

How many such periods have you had?

Do you feel that way now?

Did you ever completely recover from such a period of sadness?

How severe is/was the experience? Did it affect your work, your home life, or your social life?

Have you ever been treated for depression? If so, details?

Were you hospitalized?

During a typical period of depression:

Does your appetite go down?

Do you lose weight? If so, how much?

Does your sleep change? If so, up or down? Does it affect you most days?

Do you tend to awaken very early in the morning and be unable to get back to sleep?

Do you usually feel better in the morning or in the evening, or is there no difference?

Do you feel slowed down or speeded up? If either, is it usually enough that other people can notice?

Do you feel unusually tired or lacking in energy? If so, is this true most days?

Do you feel worthless or more guilty than warranted about something—not just about feeling sick? If so, is this true most days?

Are you indecisive, or do you have trouble focusing your concentration? If either, is this true most days?

Do you think about dying?

If so, how often does this thought occur to you?

Do you consider suicide?

If so, please tell me about that.

Have you ever made a suicide attempt?

If so, when? How?

Physically/medically serious?

Psychologically serious?

When you are depressed, do your arms or legs feel heavy, rather like lead?

When you are depressed, do you ever feel so bad that you hear or see things that others cannot see or hear? If so, details?

When you are depressed, do you ever think that you deserve to feel this bad, or that other people are trying to harm you or work against you in some other way? If so, details?

When you are depressed, have you felt that things were hopeless or there was no use?

When you are depressed, do you feel better when something good happens (for example, when you are with friends or if you get a raise)?

When you are depressed, do you feel different than you would when, say, someone close to you died?

When you are depressed, do you lose your sense of pleasure in almost everything?

Do you tend to become depressed at a particular season of the year? If so, details?

Are you the sort of person who usually (not just when depressed) feels highly sensitive to rejection?

B1. Have you ever had a time when you felt the opposite of depressed—you felt unreasonably happy, euphoric, "too happy"?

B2. Did you ever have a time when you (or others) noticed that you were unusually cross, irritable, or cranky?

B3. Have you had periods when you were much more active than is normal for you?

If "yes" to any of these three:

How long did this period last?

How many such periods have you had?

Do you feel that way now?

Did you ever completely recover from such a period of excessive happiness?

How severe is/was the experience? Did it affect your work, your home life, or your social life?

Were you given treatment in any way for such a period? If so, details?

Were you hospitalized?

During such periods:

Do you feel like you have special strengths or powers others don't have (such as having telepathy or reading minds), or that you were a special or exalted person (for example, Jesus or a movie star)? If so, details?

How is your sleep? Details?

If sleep during these periods is less than normal: Do you feel you need less sleep than usual?

Do you talk more than usual, or do others claim that you do?

Do your thoughts seem to race from one thing to another?

Do you (or others) notice that you are more easily distractible than usual?

Do you feel speeded up in your activity level, or do others say that this is the case?

Do you make more plans than you normally would?

How is your sex drive?

What about your judgment—do you think it is impaired in any way? Here's what I mean:

Do you spend money you later wished you hadn't?

Do you get into legal scrapes?

Do you pursue sex relations in a way that isn't normal for you?

Do you ever think you hear or see things that others can't see or hear? If so, details?

Do you feel spied upon or persecuted or that other people are trying to harm you or work against you in some other way? If so, details?

ANXIETY AND RELATED DISORDERS*

C1. Have you ever have an attack or spell when you suddenly felt anxious, fearful, or extremely uneasy?

C2. Have you ever had a sudden attack or spell when you felt faint, you felt you couldn't breathe, or your heart seemed to race?

If "yes" to either:

How many such attacks have you had?

How often do they occur, on average?

How long do these attacks last?

How severe is/was the experience? Did it affect your work, your home life, or your social life?

Have you ever been treated for such an episode? If so, details?

Were you hospitalized?

During these attacks, have you ever had any of these sensations:

Chest pain or other chest discomfort?

Chills or hot flashes?

Choking?

Feeling that things were unreal or that you were detached from yourself?

Feeling dizzy, lightheaded, faint, or unsteady on your feet?

Fear that you might be dying?

Fear that you would lose control of yourself or become insane?

*Incorporating the DSM-5 categories of obsessive–compulsive and related disorders and of trauma- and stressor-related disorders.

Heart pounding, racing, or skipping beats?
Nausea or other abdominal discomfort?
Numbness or tingling?
Sweating?
Shortness of breath or smothering sensation?
Trembling?

D1. Have you had fears or phobias related to anything? Examples: animals (such as spiders, dogs, snakes); blood, needles, or injections; heights; airplane travel; being closed in; thunderstorms; blushing; eating in public; speaking, singing, or playing a musical instrument before an audience.

If "yes," ask for each feared stimulus:
How often has this fear occurred?
How many episodes have you had?
Does this sort of fear seem unreasonable or out of proportion to you?
Does this fear cause you to avoid the situation?
Does it interfere with your usual routine or your work, social, or personal functioning?
Have you ever had treatment for it?

D2. Have you had anxiety about being in a place or situation (such as a store or the movies)—a place that you'd have trouble escaping from, or where there might be no help available if you had a panic attack?

If "yes":
Do you therefore sometimes avoid stores or the movies (or the other places)?
If you do go into one of these situations, do you feel anxious when you are there?
Do you ever take a companion to help you if you should have a panic attack while away from home?

E1. Have you ever had ideas or thoughts that keep coming back to you—thoughts that you try to resist but cannot?

If "yes":
How often do these ideas occur?
Do you try to resist or suppress these ideas/thoughts?
Do they come from your own mind, or does it seem that they are imposed on you from somewhere outside you?

E2. Do you ever experience physical behaviors that you feel you have to perform over and over, such as handwashing, checking the stove, or counting things?

If "yes":
Do these behaviors occur in response to an idea or thought that you can't resist, as we discussed just now?
Do they make you follow strict rules when carrying them out?
Do they prevent something bad from happening?

Do they reduce your distress?
Do they cause severe distress?
How much time do they take up?
Do they interfere with your usual routine or with work, social, or personal functioning? If so, details?

F1. Have you ever had a traumatic, stressful experience that you found you kept on reliving or having to avoid?

If "yes":
What was the event?
When did it occur?
Did it cause a sense of severe fear, horror, or helplessness?
Have you had any experiences that caused you to relive the event?
Intrusive thoughts or images?
Flashbacks, hallucinations, illusions, or feeling as if the event was recurring?
Cues that symbolize or resemble the event, causing you a lot of distress?
Physical events (such as rapid heartbeat, raised blood pressure) in response to these cues?
Have you repeatedly tried to avoid things that remind you of the trauma? If so, in which of these ways:
Have you tried to avoid feelings, thoughts, or conversations that remind you of the event?
Have you tried to avoid activities, people, or places that remind you of the event?
Have you been unable to recall any important features of the event?
If so, which?
Have you lost interest in activities that are important to you?
If so, which ones?
To what degree?
Have you felt isolated from other people?
Have you felt that you've lost the ability to feel love or other strong emotions?
Have you felt that your life would be brief or unrewarding—such as a lack of marriage, job, or children?
Have you had any of the following symptoms that weren't present before the event:
Insomnia?
Irritability?
Trouble concentrating?
Excessive vigilance (such as frequently scanning the surroundings for signs of danger)?
Increased startle response?

G1. Do you worry a great deal of the time?

G2. What do you worry about?

If patient lists three or more worries:

Do you have trouble controlling these worries?

How many days a month do you think you worry about these matters?

For how many months have you had worries like this?

Did it lead to trouble with your job, your family life, or your personal life?

When you worry:

Do you have feelings of being restless, edgy, or keyed up?

Do you get tired easily?

Do you have trouble concentrating?

Do you feel irritable?

Do you have increased muscle tension?

Do you have trouble sleeping?

PSYCHOTIC DISORDERS

H1. Have you ever had experiences like seeing visions or hearing voices that other people couldn't see or hear?

H2. Do you ever taste things or smell things that other people cannot, or feel things on your skin or in your body that other people don't?

If "yes" for voices:

How lifelike are they? Do they sound as real as my voice does now?

Do they seem to come from inside your head or somewhere outside?

When did you start hearing them?

Are they male or female?

Whose voices are they?

How many voices do you hear?

If more than one voice, do they ever talk with one another?

Do they ever talk together about you?

How often do the voices occur?

If every day, how often each day?

Do they tell you what to do?

Do you ever follow their commands?

If "yes" for visual material:

Can you see them as clearly as you see me now?

When do you see them?

If every day, how often each day?

When did you start seeing them?

If "yes" for tastes, smells, or tactile sensations:

Please describe these sensations.

How often do you experience them?
If every day, how often each day?
What are you doing when you experience them?
When did you start having them?

For all hallucinations:
What do you think causes these experiences to occur?
Could there be any connection between these experiences and drug or alcohol use, or the use of medication?
Have you had any physical illness that could help account for these experiences?

J1. Have you ever felt that people were spying on you, talking behind your back, or working against you in some other way?

J2. Have you ever felt you had some sort of a special mission in life—perhaps a divine purpose or higher calling?

J3. Have you had some other seemingly strange experience you couldn't explain or account for?

[If patient needs additional information: Here are some examples of the sort of thing I mean:
Have you ever felt that people could hear your unspoken thoughts or read your mind?
Have you ever felt that someone on TV or the radio was sending messages that were meant for you alone?
Have you ever thought that someone from outside could put thoughts into your mind or take them out?
Have you ever felt that you've done something so awful that you deserve punishment for it?
Have you ever felt that you were someone famous, or that you had abilities or powers that other people don't have?]

If "yes" to any of the three J questions:
Specifically, what have you noticed?
How long have you had these experiences?
Who or what do you think has been responsible for these events?
How have you tried to combat them?
Has anyone close to you had similar experiences?
Could there be any connection between these experiences and drug or alcohol use?

SUBSTANCE MISUSE

K1. Have you ever used alcohol or street drugs?

K2. Have you ever taken prescription or over-the-counter medication in a way that was different from the recommendation or prescription?

K3. Have you ever felt you drank or used drugs to excess?

K4. Have other people ever expressed concern about your drinking or drug use?

If "yes" to any of these:

Which substances?

How long have you used them?

Do you use them now?

Have you ever had withdrawal symptoms when coming off a specific substance?

Alcohol/sedatives/hypnotics/anxiolytics: sweating, rapid heartbeat, tremor, sleeplessness, nausea, vomiting, brief hallucinations or illusions, speeded-up activity, grand mal seizures, anxiety?

Cocaine/amphetamines: Sad or depressed mood, fatigue, vivid bad dreams, sleep increased or decreased, increased appetite, activity speeded up or slowed down?

Opioids: Sad or depressed mood, nausea, vomiting, aching muscles, tearing, runny nose, dilated pupils, erect hairs, sweating, diarrhea, yawning, fever, sleeplessness?

Have you ever found yourself having to use increasing amounts of the substance to get the same effect?

Have you ever found that you've used more of the substance than you meant to?

Have you tried to control your use of the substance, but found you couldn't?

Does your substance use occupy a lot of your time—getting it, using it, or recovering from its effects?

Have you found that your substance use has caused you to abandon important work, social, or leisure activities such as home life or getting together with friends?

Has your substance use caused you distress or impaired your functioning?

If so, how?

Have you continued to use the substance, even though you knew that it was probably causing you to have physical or psychological problems?

Has substance use ever caused you not to fulfill major obligations, such as attending school, going to work, or taking care of children?

Have you used substances even when doing so was physically dangerous—such as driving a vehicle?

Has substance use caused you to have legal problems?

If so, how many, and when?

Has substance use ever caused you to have social or interpersonal problems?

If so, did you continue to use the substance anyway?

Do you find that you crave the substance?

DIFFICULTY THINKING (COGNITIVE PROBLEMS)

L1. How has your memory been? I'd like to test it, if that's OK.
Repeat back to me [a name, a color, a street address].
What's the date today?
Who is the current president [prime minister]? Name the one just before this person . . . And now the three before that person.
Please subtract 7 from 100. Now 7 from that . . . Good, and keep going until you get below 60.

L2. Have you ever had experiences or periods in your life that you couldn't remember later?
If so, please tell me about it.
How often has this happened?

L3. Did you ever find yourself in a strange location and couldn't remember how you got there?
If so, please tell me about it.
How often has this happened?

What were those three items I asked you to repeat a few minutes ago?

PHYSICAL COMPLAINTS

M1. Has your general health always been good?

M2. Have you had much medical attention for different conditions?
[Regardless of answers to screens:]
What illnesses have you had? Details?
Have you had other medical conditions?
Use of medications?
Then, if "no" to M1 or "yes" to M2:
Now I'd like to ask about some symptoms people sometimes experience.
Have you ever had:
Pain symptoms, such as these:**
Head pain (other than headache)?
Abdominal pain?
Back pain?
Pain in your joints?
Pain in your arms or legs?
Chest pain?

**To count as positive, each symptom must have (1) not been fully explained by a general medical condition or substance use; *and* (2) caused impairment or caused the patient to seek treatment; *and* (3) exceeded the discomfort or impairment you'd expect for any medical condition that seems related.

Rectal pain?
Pain with menstruation?
Pain with sexual intercourse?
Pain on urination?

Gastrointestinal symptoms, such as these:*
Nausea?
Abdominal bloating?
Vomiting (other than during pregnancy)?
Diarrhea?
Intolerance of several foods?

Sexual and genitourinary symptoms, such as these:*
Indifference to sex?
Difficulties with erection or ejaculation?
Irregular menses?
Excessive menstrual bleeding?
Vomiting throughout all 9 months of pregnancy?

Neurological symptoms, such as these:*
Impaired balance or coordination?
Weak or paralyzed muscles?
Lump in throat?
Trouble swallowing?
Loss of voice?
Retention of urine?
Hallucinations?
Numbness (to touch or pain)?
Double vision?
Blindness?
Deafness?
Seizures?
Amnesia?
Other dissociative symptoms?
Loss of consciousness (other than fainting)?

N1. Have you ever felt fat when people said you were too thin?

N2. Did you ever make yourself throw up because you felt so full?

If "yes" to either:
When was it?
Is this still the case?
What did you weigh then?
How tall were you then?
Were you afraid of gaining weight?
Did you exercise a lot to lose weight?
Did you ever use laxatives to lose weight?

At that time, how did your body look to you? Thin, fat, or about right?

How important was your body weight or shape to you then?

N3. Do you ever go on eating binges, when you rapidly eat far more than normal?

If "yes":

How often does this occur?

At these times, do you feel you've lost control of your eating?

To keep from gaining weight, do you ever use laxatives? Use diuretics? Throw up? Fast? Exercise a lot?

P1. Have you ever felt or feared that there was something terribly wrong with you physically—some serious condition that doctors couldn't identify?

If "yes":

Please describe your symptoms.

How long have they lasted?

What disease or condition are you afraid of?

Q1. Have you ever felt that there was something about your body or your appearance that wasn't right—something that other people didn't seem to recognize?

If "yes":

Do you spend a lot of time thinking about this problem, or trying to deal with it?

What steps have you taken to remedy it?

IMPULSE-CONTROL DISORDERS

R1. Do you easily become angry?

If "yes":

In what sorts of situations do you become so angry?

Do you become so angry that you lose control?

As a result, do you ever destroy property? If so, how often?

As a result, do you ever assault another person? If so, how often?

S1. Do you ever behave impulsively?

S2. Do you ever do things like pull out strands of your hair . . . or become destructively aggressive . . . or steal from stores . . . or set fires? [Pause for response between symptoms.]

If "yes" to any:

Do you feel a sort of tension just before performing any of these activities?

Do you feel gratification, pleasure, or relief during or after the activity?

T1. Do you gamble?

If "yes":

How often?

Have you ever felt that you gambled excessively—that it was out of control?

Do you find that gambling preoccupies you—that you spend a lot of time figuring out how to get money to gamble, or reliving your past gambling experiences, or planning new gambling ventures?

Have you ever needed to put more money into play to achieve the same excitement?

Have you tried to control your gambling and couldn't?

If so, how?

How many times has this happened?

Have you felt restless or irritable when trying to control your gambling?

Do you ever gamble as an escape from your problems or to cope with depressed or anxious moods?

Have you ever gambled to try to recoup your losses?

Have you ever lied to conceal how much you've lost gambling?

Have you ever had to rely on other people for money to cover your gambling debts?

Have you ever used money that wasn't yours to gamble with?

Has gambling ever jeopardized a job, an important relationship, or a chance for your career or education?

FAMILY HISTORY

U1. Has any blood relative—by which I mean a parent, brother, sister, grandparent, child, aunt, uncle, cousin, niece, or nephew—ever had symptoms like yours?

U2. Has any of these relatives had any mental illness, including depression . . . mania . . . psychosis . . . schizophrenia . . . nervousness . . . severe anxiety . . . mental hospitalization . . . suicide or suicide attempt . . . substance misuse or alcoholism . . . or a history of criminal behavior? [Pause for response between illnesses.]

For any positive response:

What were this person's symptoms?

How old was the person at the time?

Do you know what treatment was given?

What happened to this person? [Possibilities might include recovery, continued illness but functioning in society, inability to work, repeated or chronic hospitalization.]

CHILDHOOD THROUGH ADULT LIFE

Childhood

Where were you born?
How many brothers and sisters did you have?
Were you the oldest, youngest—which number in the list?
Were you reared by both parents?
How did your parents get along?
  If they fought, what about?
  If they divorced or separated, how old were you then?
With whom did you live?
If you were adopted, how old were you at the time?
  Do you know what the circumstances behind the adoption were?
How was your health as a child?
How far did you go in school?
  Were you ever held back in school?
  Any behavior or disciplinary problems in school?
  Any truancy?
  Were you ever suspended or expelled?
Did you have many friends as a child?
What interests and hobbies did you have as a child?
Outside of school, did you have legal or disciplinary problems?
  If so, did you ever steal things?
  Set fires?
  Deliberately destroy the property of others?
  Behave cruelly toward people or animals?
  Run away from home overnight?

Adult Life

Are you married?
  If so, number of times, and your age each time?
  How did early marriage(s) end—divorce, death of spouse?
With whom do you live now?
Number of children, ages?
Do you have any stepchildren?
  If so, how many?
  How is your relationship with them?
What is your current occupation?
Number of jobs lifetime?
  Reasons for job changes?
  Were you ever fired? Why?
If you are not working now, what is your current means of support?

Any military service?
  If so, which branch?
  Number of years?
  Highest rank attained?
  Combat experience?
  Disciplinary problems in military?
How important is religion to you now?
  What is your current religious affiliation?
  Is it different from the religion of your childhood?
  If so, what made you change?
What are your current leisure activities?
  Clubs, organizations?
  Hobbies, interests?
When did you first learn about sex?
What were the circumstances?
How old were you when you began dating?
How old were you at your first sexual experience?
  What was its nature?
  How did you feel about it?
Can you tell me about your current sexual interests?
Have there ever been sexual practices or experiences that troubled you?
Were you ever abused as a child?
  Sexually?
  Physically?
As an adult, were you ever raped or sexually abused? If so, details?

SOCIAL AND PERSONALITY PROBLEMS

The following questions will elicit information about how patients view themselves and interact with others. In most cases, the answers will not allow you to make a firm diagnosis; you will need to obtain further information from other resources.

What sort of a person do you think you are?
What do you like most about yourself?
What do you like least about yourself?
Do you have many friends, or are you more of a loner?
How well do you get along with your [husband/wife/partner]?
Do you have any problems in getting along with members of your family?
Do you avoid any of your relatives because of difficulties getting along?
Any difficulties with friends?

Have you had any interpersonal problems at work?
Do you tend to be suspicious of people's motives, or are you more a trusting sort of person?
Do you like being the center of attention, or are you more comfortable staying in the background?
Are you usually comfortable being by yourself, or do you find you need the presence of other people?
Have you ever done something that turned out to be poor judgment? If so, what was it?
Have you ever had some sort of legal difficulty? If so, give details.
Have you ever been arrested? Spent time in jail? If so, give details.
Have you ever done something that could have gotten you into legal difficulties, but you were never found out?
When you do [these behaviors], do you tend to feel sorry afterward?
Do you feel that other people would like to deceive, exploit, or harm you?
If so, give examples.
Do you feel that your friends or acquaintances are disloyal to you? If so, give examples.
Do you tend to bear grudges? If so, give examples.
Do you prefer to do things by yourself? If so, give examples.
Does criticism or praise affect you much? If so, give examples.
Are you a superstitious person? If so, give examples.
Do you believe in the supernatural, such as telepathy, black magic, mind reading? If so, give examples.
Are your relationships with other people usually long-lasting? If so, give examples.
Does your mood tend to be pretty stable, or are you more of an up-and-down sort of person? If so, give examples.
Do you tend to describe yourself as feeling "empty"? If so, give examples.
Do you feel angry much of the time or frequently lose your temper or get into fights? If so, give examples.
Do you like being the center of attention? If so, give examples.
Do you feel that you are easily influenced by the opinions of other people? If so, give examples.
Do you often have fantasies about yourself as achieving vast success, ideal love, power, brilliance? If so, give examples.
Do you often feel that you deserve special treatment or consideration? If so, give examples.
Is it hard for you to identify with the feelings of other people? If so, give examples.
Do you fear embarrassment or disapproval so much that you avoid new activities or interactions with other people? If so, give examples.

In new relationships, do you often feel inadequate? If so, give examples.

Do you feel you need a lot of advice and reassurance when making everyday decisions? If so, give examples.

Does the fear that you'll lose support make it hard for you to disagree with others? If so, give examples.

Do you get so preoccupied with details that you sometimes lose sight of the purpose of what you are doing? If so, give examples.

Do you regard yourself as being especially stubborn? If so, give examples.

Would you say that you are a perfectionist? If so, give examples.

APPENDIX E

Assessing Your Interview

All patients, and therefore all interviews, are different. Instructors also vary in the emphasis they place on the several aspects of the initial interview. However, there are many aspects that most clinicians agree are crucial for the typical interview. These aspects include factual material, as well as items that contribute to the process of obtaining information. They are listed in this appendix, where a rough numerical value is assigned to each.

You can score your own interview from an audio or video recording, or have a colleague do it for you while you are interviewing. The overall score and subsection scores should help you plan where to expend additional effort. The scoring system used has been based on, and extended from, articles by Maguire and associates (see Appendix F).

For each section of this assessment, score 0 if the rated behavior or item of data was not observed or covered at all. Score the maximum number of points if the item was covered completely (as judged from the patient's case notes in the chart), or for desired behavior that was consistently present. Give proportional credit for partial answers or behaviors.

The maximum score is 200 points. For a beginner, any score above 140 may be considered acceptable, though advanced interviewers should average much higher.

Mental status data are not included in this self-assessment, which was designed to evaluate only the historical and interactive portions of the initial interview.

1. *Initiating the interview* (10 points)

Interviewer	No	Yes
a. Greets the patient	0	1
b. Shakes hands	0	1
c. Mentions patient's name	0	1
d. Mentions own name	0	1
e. Explains status (training?)	0	1
f. Indicates where to sit	0	1
g. Explains purpose of interview	0	1
h. Mentions time available	0	1
i. Mentions note taking	0	1
j. Asks whether patient is comfortable	0	1

2. *History of present illness* (58 points)

Interviewer asks about . . .	No								Yes
a. Main complaint(s)	0	1	2	3	4	5	6	7	8
b. Onset of problems	0		1		2		3		4
c. Stressors	0		1		2		3		4
d. Key events in course of illness	0		1		2		3		4
e. Current medications									
1. Names or descriptions	0				1				2
2. Doses	0				1				2
3. Wanted effects obtained	0				1				2
4. Side effects noted	0				1				2
5. Duration of effects	0				1				2
f. History of previous episodes									
1. Type	0		1		2		3		4
2. Similarity to present episode	0		1		2		3		4

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3. Previous treatment	0	1	2	3	4
4. Outcome of treatment	0	1	2	3	4
g. Effects of illness on work	0	1	2	3	4
h. Effects of illness on family	0	1	2	3	4
i. Patient's feelings about problems	0	1	2	3	4

3. *Medical history* (10 points)

Interviewer asks about . . .	No		Yes
a. Relevant data on physical illnesses	0	1	2
b. Allergies to medications	0	1	2
c. Operations	0	1	2
d. Previous hospitalizations	0	1	2
e. Relevant review of systems	0	1	2

4. *Personal and social history* (20 points)

Interviewer asks about . . .	No		Yes
a. Details of family of origin	0	1	2
b. Education	0	1	2
c. Marital history	0	1	2
d. Military history	0	1	2
e. Work history	0	1	2
f. Sexual preference and adjustment	0	1	2
g. Legal problems	0	1	2
h. Current living situation	0	1	2
i. Leisure activities	0	1	2
j. Source of support	0	1	2

5. *Family history of mental disorder* (6 points)

Interviewer asks about . . .	No		Yes
a. Symptoms to make diagnosis	0	1	2
b. Response to treatment	0	1	2
c. All first-degree relatives	0	1	2

6. *Screening questions* (26 points)

Interviewer screens for . . .	No				Yes
a. Depression	0		1		2
b. Panic attacks	0		1		2
c. Phobias	0		1		2
d. Obsessions and compulsions	0		1		2
e. Mania	0		1		2
f. Psychosis	0		1		2
g. Childhood abuse	0		1		2
h. Substance misuse (including medications)	0	1	2	3	4
i. Suicidal ideas/attempts	0	1	2	3	4
j. History of violence	0	1	2	3	4

7. *Establishing rapport* (18 points)

Interviewer	No				Yes
a. Smiles, nods at appropriate times	0	1	2	3	4
b. Uses language patient understands	0	1	2	3	4
c. Responds with feeling, empathy	0	1	2	3	4
d. Maintains eye contact	0		1		2
e. Maintains appropriate distance	0		1		2
f. Appears self-assured and relaxed	0		1		2

8. *Use of interview techniques* (44 points)

Interviewer . . .	Poor				Good
a. Explores verbal leads to new material	0	1	2	3	4
b. Controls flow of interview while allowing patient scope for response	0	1	2	3	4
c. Clarifies uncertainties to obtain complete information	0	1	2	3	4
d. Makes smooth transitions; if abrupt, they are pointed out	0	1	2	3	4
e. Avoids use of jargon	0	1	2	3	4

f. Asks brief, single questions	0	1	2	3	4
g. Does not repeat questions already asked	0	1	2	3	4
h. Uses open, nondirective questions	0	1	2	3	4
i. Facilitates patient's replies verbally and nonverbally	0	1	2	3	4
j. Encourages precise answers (dates, numbers where appropriate)	0	1	2	3	4
k. Seeks out and sensitively handles emotionally loaded material	0	1	2	3	4

9. *Ending the interview* (8 points)

Interviewer . . .	No		Yes
a. Warns that interview is nearly over	0	1	2
b. Gives brief, accurate summary	0	1	2
c. Solicits questions from patient	0	1	2
d. Makes a concluding statement of appreciation, interest	0	1	2

APPENDIX F

Bibliography and Recommended Reading

BOOKS

Included here are the most recent editions available when we went to press; since then, some may have been revised.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author. [The bible of current diagnostic thinking.]

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Ekman, P. (2009). *Telling lies: Clues to deceit in the marketplace, politics, and marriage* (4th ed.). New York: Norton. [A great deal of information about lying and its detection.]

Gill, M., Newman, R., & Redlich, F. C. (1954). *The initial interview in psychiatric practice.* New York: International Universities Press. [Classic description of an interviewing style that focuses on the patient's needs and capabilities.]

Leon, R. L. (1989). *Psychiatric interviewing: A primer* (2nd ed.). New York: Elsevier. [This volume covers much of the same material as *The First Interview*. The author explicitly favors a nondirective approach to gathering information.]

MacKinnon, R. A., & Yudofsky, S. C. (1986). *The psychiatric evaluation in clinical practice*. Philadelphia: Lippincott. [Only the first third of this book concerns clinical interviewing. The balance is given over to clinical laboratory testing, personality tests, and rating scales. The section on psychodynamic case formulation provides some information not readily available elsewhere.]

Morrison, J. (2014). *DSM-5 made easy: The clinician's guide to diagnosis*. New York: Guilford Press. [A learner's guide to the increasingly complex and lengthy *Diagnostic and statistical manual of mental disorders*.]

Morrison, J. (2014). *Diagnosis made easier* (2nd ed.). New York: Guilford Press. [Step by step, this book helps the reader make sense of the interview material. Newly revised to reflect DSM-5 changes.]

Othmer, E., & Othmer, S. C. (2002). *The clinical interview using DSM-IV-TR*. Washington, DC: American Psychiatric Press. [Encyclopedic in its coverage, this book adheres strictly to the official DSM format.]

Oyebode, F. (2008). *Sims' symptoms in the mind*. Edinburgh/New York: Saunders Elsevier. [This British text contains more in the way of current mental health terminology and definitions than any other I have seen.]

Shea, S. C. (1998). *Psychiatric interviewing: The art of understanding* (2nd ed.). Philadelphia: Saunders. [Though a bit long-winded, it nevertheless presents a great deal of relevant material.]

Sullivan, H. S. (1954). *The psychiatric interview*. New York: Norton. [An early, classic description of how to do an initial interview.]

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Maguire, C. P., & Rutter, D. R. (1976). History-taking for medical students. 1: Deficiencies in performance. *Lancet, ii,* 556–560. [Senior medical students showed significant deficiencies in taking histories. These included avoidance of personal issues, use of jargon, lack of precision, failure to pick up on cues, needless repetition, poor clarification, failures of control, inadequate facilitation, and inappropriate question style (leading or complicated questions).]

Maguire, P., Roe, P., Goldberg, D., Jones, S., Hyde, C., & O'Dowd, T. (1978). The value of feedback in teaching interviewing skills to medical students. *Psychological Medicine, 8,* 695–704. [In a randomized trial, feedback (video, audio,

or ratings of practice interviews) led to greater ability to obtain relevant, accurate facts. Only the video and audio groups also showed improved technique.]

Maguire, P., Fairbairn, S., & Fletcher, C. (1986). Consultation skills of young doctors. I: Benefits of feedback training in interviewing as students persist. *British Medical Journal, 292,* 1573–1576. [Young physicians who had either been given feedback training by video or allotted to conventional teaching in interview skills were followed up 5 years later. Both groups had improved since graduation, but "those given feedback training had maintained their superiority in the skills associated with accurate diagnosis." The authors conclude that feedback training should be given to all students.]

Platt, F. W., & McMath, J. C. (1979). Clinical hypocompetence: The interview. *Annals of Internal Medicine, 91,* 898–902. [House officers in internal medicine had problems with initial interviews. These included poor rapport, inadequate database, failure to formulate hypotheses, excessive control of interview (patients complained of not being listened to), and acceptance of patients' reports of lab data or interpretations of what another health care provider said, rather than the primary data of symptoms. Examples are given.]

Rutter, M., & Cox, A. (1981). Psychiatric interviewing techniques: I. Methods and measures. *British Journal of Psychiatry, 138,* 273–282. [The introductory article in this series. The series of seven articles by these authors is a landmark in the study of interview technique. These studies are based on interviews with mothers of child psychiatry patients and compare four interviewing styles that have been recommended by experts. Although the research they report has not been replicated, the findings are so logical and the methodology so impeccable that they strike the reader as received truth. These articles provide much of the basis for this manual.]

Cox, A., Hopkinson, K., & Rutter, M. (1981). Psychiatric interviewing techniques: II. Naturalistic study: Eliciting factual material. *British Journal of Psychiatry, 138,* 283–291. [This article demonstrates that "a directive style with specific probes and requests for detailed descriptions" produced facts of better quality than did an approach that was more freestyle. Informants talked more when interviewers talked less and used more open-ended questions. Double questions led to confusion, but multiple-choice questions were sometimes helpful.]

Hopkinson, K., Cox, A., & Rutter, M. (1981). Psychiatric interviewing techniques: III. Naturalistic study: Eliciting feelings. *British Journal of Psychiatry, 138,* 406–415. [Several techniques were found to facilitate expression of emotion. These included "a low level of interviewer talk with few interruptions, a high rate of open rather than closed questions, direct requests for feelings, interpretations and expressions of sympathy."]

Rutter, M., Cox, A., Egert, S., Holbrook, D., & Everitt, B. (1981). Psychiatric interviewing techniques: IV. Experimental study: Four contrasting styles. *British Journal of Psychiatry, 138,* 456–465. [The authors taught two interviewers to use any of four interviewing styles: (1) A "sounding board" style used minimal activity; (2) "active psychotherapy" tried to explore feelings and elicit

emotional linkages and meanings; (3) a "structured" style used active cross-questioning; (4) a "systematic exploratory" style combined high use of both fact- and feeling-oriented techniques.]

Cox, A., Rutter, M., & Holbrook, D. (1981). Psychiatric interviewing techniques: V. Experimental study: Eliciting factual material. *British Journal of Psychiatry, 139,* 29–37. [This paper reports data on the study described just above. The authors conclude that "it is desirable to begin clinical diagnostic interviews with a lengthy period with little in the way of detailed probing and in which informants are allowed to express their concerns in their own way." Systematic questioning is essential to elicit good-quality facts. "Better data were obtained when interviewers were sensitive and alert to factual cues and chose their probes with care."]

Cox, A., Holbrook, D., & Rutter, M. (1981). Psychiatric interviewing techniques: VI. Experimental study: Eliciting feelings. *British Journal of Psychiatry, 139,* 144–152. [A variety of interview styles can be used to elicit feelings from patients. Gathering good factual information is entirely compatible with eliciting feelings.]

Cox, A., Rutter, M., & Holbrook, D. (1988). Psychiatric interviewing techniques: A second experimental study: Eliciting feelings. *British Journal of Psychiatry, 152,* 64–72. [Expression of emotions was maximized when interviewers used "active" techniques, such as interpretation, reflection of feelings, and expression of sympathy. This was especially true if the informant's "spontaneous rate of expression was relatively low."]

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